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ABSTRACT

The manual is intended for special educators providing inservice training to personnel who work in early childhood centers which serve handicapped children in mainstreamed day care, preschool, and Head Start settings. An introduction summarizes research on inservice training, presents an inservice delivery model, includes 7 sample forms, and lists 13 references. An introduction and planning session section outlines objectives and activities and provides several questionnaires, a sample teacher observation rating scale, and a sample planning sheet, as well as handouts on using a teacher consultant and on defining integration. A separate section is then given to each of the following topics: preparing an environment for a young child with special needs, teaching strategies, behavior management, dealing with parents, and characteristics of various handicapping conditions with tips for dealing with them. Included in each section are background information for the instructor, an outline for the presentation, handouts for participants, activities to use with participants, and assignments to be completed by participants. An appendix includes a variety of resources including fact sheets on many disabilities, miscellaneous forms, a glossary, the "Early Childhood Environmental Rating Scale," an inservice evaluation form, media/resource information, and a booklet containing a collection of socio-dramatic play ideas for the classroom. (DB)

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WE'RE IN THIS TOGETHER (W.I.T.)

RESOURCE MANUAL FOR INTEGRATING HANDICAPPED CHILDREN INTO DAY CARE AND PRESCHOOL PROGRAMS

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HOW TO USE THIS MANUAL

HOW TO USE THIS MANUAL

Who this training manual is for:

This training manual is for individuals with a background in special education/early childhood or related fields who work with early childhood center personnel serving handicapped children in their "regular" setting.

This manual is meant to be a resource or supplement to regular visits. Support in the form of visits will not only help determine day care preschool staff needs, but is also an important factor cited in teacher in-service literature dealing with integration. This manual may be used in its entirety or sections may be removed depending on staff needs, interests and the size of the group. (Information on in-service technique and type of service delivery model are in the Introduction section.)

How this manual is organized:

White — Each section consists of some **background information** for the instructor to read as well as a suggested outline for presentation.

Blue — **Handouts** for participants.

Yellow — **Activities** that may be used with participants. The activity section is an important part of the training manual. The activities give participants an opportunity to practice what's presented and to integrate some of their past knowledge and experience with newly presented information.

Pink — **Assignments** to be completed by participants.

The appendix includes miscellaneous forms, a glossary, "Early Childhood Environmental Rating Scale" and media/resource information.

Presentation:

Effective teaching research, conducted since 1974, has yielded a pattern of instruction that is particularly useful for teaching a body of content, or well defined skills. The pattern includes a systematic method for presenting material in small steps, checking for understanding and eliciting successful participation from all students.

Researchers have found, in general, that when effective teachers teach they:

- begin with a short statement of goals
- review previously presented information
- present material in small steps
- provide active practice for all participants
  This moves new learning from working memory into long-term memory.
- ask questions, check for understanding, obtain responses from all participants
- guide participants during initial practice
- provide feedback or corrections
- provide opportunities for independent practice

INTRODUCTION

PURPOSE

This manual has been developed to provide educators with a guide for preparing general early childhood personnel who are integrating handicapped children into their centers.

The preschool/integration project (We're in This Together) was developed by the Early Childhood/Special Education Program (Des Moines Independent School District) and day care, preschool and Head Start personnel who serve handicapped preschool-aged children. A task force consisting of representatives from interested parties was formed to identify the needs of general preschool settings when integrating handicapped children, and to generate ideas for meeting these needs.

GOALS

General goals were developed to meet the training needs of preschool/kindergarten/day care providers. They are:

1. Develop needs assessment to determine personnel needs.
2. Determine current practices in the field of integration of young children.
3. Develop training package for day care/preschool personnel based on needs assessment.
4. Provide training options for early childhood educators and day care providers.
5. Provide routine coaching to early childhood personnel.
6. Provide provisions for appropriate materials and resources for working with children who have handicaps.

CURRENT IN-SERVICE RESEARCH

Meeting the staff development needs of day care/preschool personnel has been approached in a variety of ways. They vary in context and format, but generally have a common purpose. Staff development programs are usually designed to modify professional practices, beliefs and the understanding of school personnel to move towards an articulated end (Griffin, 1983). Therefore, staff development/in-service opportunities should be designed to bring about changes in the classroom and the practices of teachers. There should be a modification in the teachers' attitudes and an improvement in the students' learning outcome (Browder, 1983; Guskey, 1986).

Staff development and in-service programs appeal to teachers. They believe the programs give them potential to expand their knowledge and skills, contribute to their growth and enhance their effectiveness with students. Teachers involved in staff development hope to gain specific, concrete and practical ideas that directly relate to the day-to-day operations of their classroom (Harootunian, 1980; Lortie, 1975; Hentschell, 1977). Therefore, in-service programs should include opportunities to practice in the classroom with feedback, demonstrations and use of media (Mann, 1976). Participants should be able to choose the options within the in-service content that are most critical to their needs. (Skrtic et al., 1979). In addition, the trainer needs to visit each early childhood environment, if possible, to know what context the training should involve. Staff development activities given outside of the teacher's area of responsibility tend to have little impact on teaching practices or student learning. (Doyle and Ponder, 1977; Zigarmi, Betz and Jensen, 1977).

The process of teacher change is also a consideration that needs to be addressed. Lewin's (1935) model has been used widely as a theoretical base for changing beliefs, perceptions and attitudes of adults. The Lewin model presumes that a change in the teacher's beliefs and attitudes will lead to specific changes in classroom behaviors and practices. This, in turn, will result in improved student learning.

Larrivee (1981) found that teachers attitudes towards integration of handicapped children in their classroom was influenced by several factors. These include: the teachers information level, knowledge attainment, skill acquisition, supportive assistance and contact with exceptional children. He emphasizes that monthly meetings, with little contact between teachers and trainer, have not been found to be effective. In-services that were only comprised of weekly sessions at individual schools, with no opportunity to consult with teachers in their classrooms was also found to be noneffective. However, Larrivee did find that intensive training, including daily sessions with

consultation and support to personnel over a 6 week period, tended to show a positive change in teacher attitudes and child outcomes.

Guskey (1986) proposes an alternative model that examines the process of teacher change along with the order of the changes. According to Guskey, significant change in the teacher's attitudes is likely to take place only after the student changes are evidenced (See Figure 1). Teachers tend to repeat activities they find successful, while those that are not successful are generally avoided. Without a positive response from the students, attitude change among teachers regarding new ideas and innovations is unlikely (Bolster, 1983).

Based on teacher in-service research, training for preschool personnel needs to include the following to promote attitude changes and enhance effectiveness with handicapped children:

a. **Information** explained in concrete terms and aimed at specific skills.

b. Addressing the **personal concerns** of the trainees by resolving their concerns about how it will effect them specifically.

c. A trainer that is perceived to be a **credible person** by participants.

d. Regular **feedback** from personnel regarding children's progress.

e. Regular training schedule of **support** and **follow-up** after the initial training.

General guidelines for planning and identifying components for effective in-service training should include:

* Identifying objectives based on the personnel identification of needs and validation of those needs by observations.

* Incentives for participation by creating an appealing in-service format.

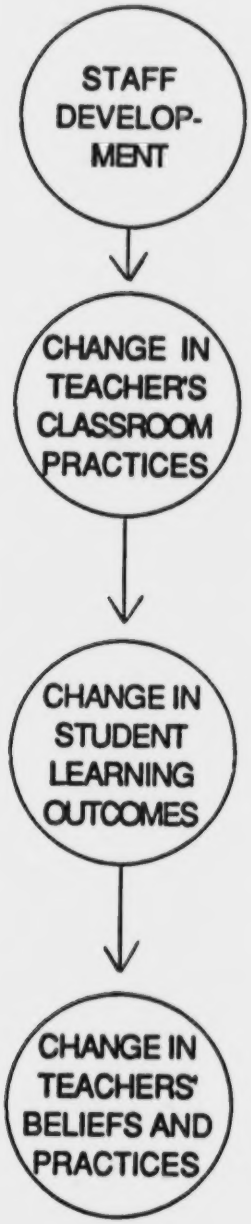
* Recognition of student progress. (Browder, 1983)

Developing an in-service training program is a process that must be carefully planned. Current literature in the field of in-service training and its relation to

Developing an in-service training program is a process that must be carefully planned. Current literature in the field of in-service training and its relation to regular preschool/ day care settings should be utilized. The effectiveness of the in-service training program will be demonstrated with positive child outcomes.

This training manual will outline suggested service delivery models along with a variety of materials. These should be used to carry out activities that are planned jointly between the trainer and participants.

FIGURE 1. GUSKEY'S MODEL FOR PROCESS OF TEACHER'S ATTITUDES


STAFF DEVELOP-MENT
CHANGE IN TEACHER'S CLASSROOM PRACTICES
CHANGE IN STUDENT LEARNING OUTCOMES
CHANGE IN TEACHERS' BELIEFS AND PRACTICES

AN IN-SERVICE DELIVERY MODEL FOR EARLY CHILDHOOD PERSONNEL

A delivery system for preparing early childhood personnel should incorporate several important factors. (See Figure 2.) A brief discussion of each part of the model is included below.

Referral or Request for Assistance:
Request for assistance from an early childhood program may be solicited in a variety of ways. The request may come from:

1. The teacher or administrator who has received notification that a handicapped child is being enrolled in their program.

2. A parent who has placed or is planning to place their handicapped child in a regular setting.

3. A support staff member of the special education program who has concerns about a child in a regular early childhood setting.

4. The director or administrator of an early childhood program who routinely enrolls handicapped children into a center.

The request should be documented and a release of information signed between the parent/guardian and the agency or school requesting information. (See attachment, Figure A1.)

Initial Contact with Agency:
The purpose of the first contact is to determine the initiator's concerns and general needs. It is also for reviewing the services offered by the early childhood special education program. If appropriate, referral procedures are reviewed for concerns of individual children who are not enrolled in a special education program.

General anecdotal information should be documented, and a date set to meet with staff members to plan in-service activities. (See Figure A2.) A needs assessment should be left with the director or administrator with instructions for distribution to appropriate staff members and to be returned to you before the next meeting (a manilla envelope can be left with return address and postage for easy return). (See Figure A3.)

Orientation and Planning Meeting:
The purpose of this meeting is to meet the staff, fill out necessary forms and complete in-service planning.

The agenda should include:

1. Introductions
2. Statement of your purpose
3. Completion of questionnaire (See Figure A4.)
4. Explanation of observations

(A simple explanation is suggested, i.e. "Next Tuesday I will be in visiting each class for about 1 hour to get an idea of the kinds of children there are in each area, and what your classroom is like.)

The actual planning session will include direct input from the participants using a nominal group approach. (The activity is described in the Planning and Introduction section, Activity #1.)

Observation of Environment and Staff:
The Early Childhood Environmental Rating Scale (Harms, et al, 1986) is an excellent tool for determining the quality of the early childhood center. The rating scale should be used before the planning session with personnel, and can be used to determine strengths and weaknesses of the environment. (See appendix for complete rating scale.) A general observation of teachers' teaching skills should also be observed. (An example of an adaption of the Carolina teacher observation tool, Figure A5.)

Schedule is Developed:
The ideas from the planning session along with observations of the environment and staff are organized within a schedule and a copy sent to each participant.

In-service Training:

The in-service plan not only includes training sessions given on a small group basis, but also support, coaching and observation in the classroom. On days that in-services are provided it is suggested that the trainer visit each classroom for about one-half hour prior to the scheduled meeting for the purpose of:

A. Observation (lowest priority)
B. "Coaching" (reinforcing staff's skills, demonstrating teaching strategies)
C. Offering support (observing children's behavior, assisting with children, offering suggestions when asked)

Attendance can be taken each visit to document hours for CEO's (See Figure A7), and a certificate of training can be sent to each participant. (See Appendix D.)

This text offers outlines and materials (handouts, activities, assignments, information) that may be used during the training sessions. The training text is meant only as a guide and was not intended as an exclusive curriculum to meet all needs.

Below is a list of other training materials for in-servicing preschool staff involved in integration:

Project Neighborcare Training Manual for Family Day Care (Appropriate for all early education programs) Pierce Hall, Purdue University, West Lafayette, IN 47907.

Mainstreaming Children With Handicap in Day Care and Preschool, A manual of training activities, Project Mainstream, Madison Area Technical College, 211 North Carroll Street, Madison, WI 53703.

Family Day Care Materials, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

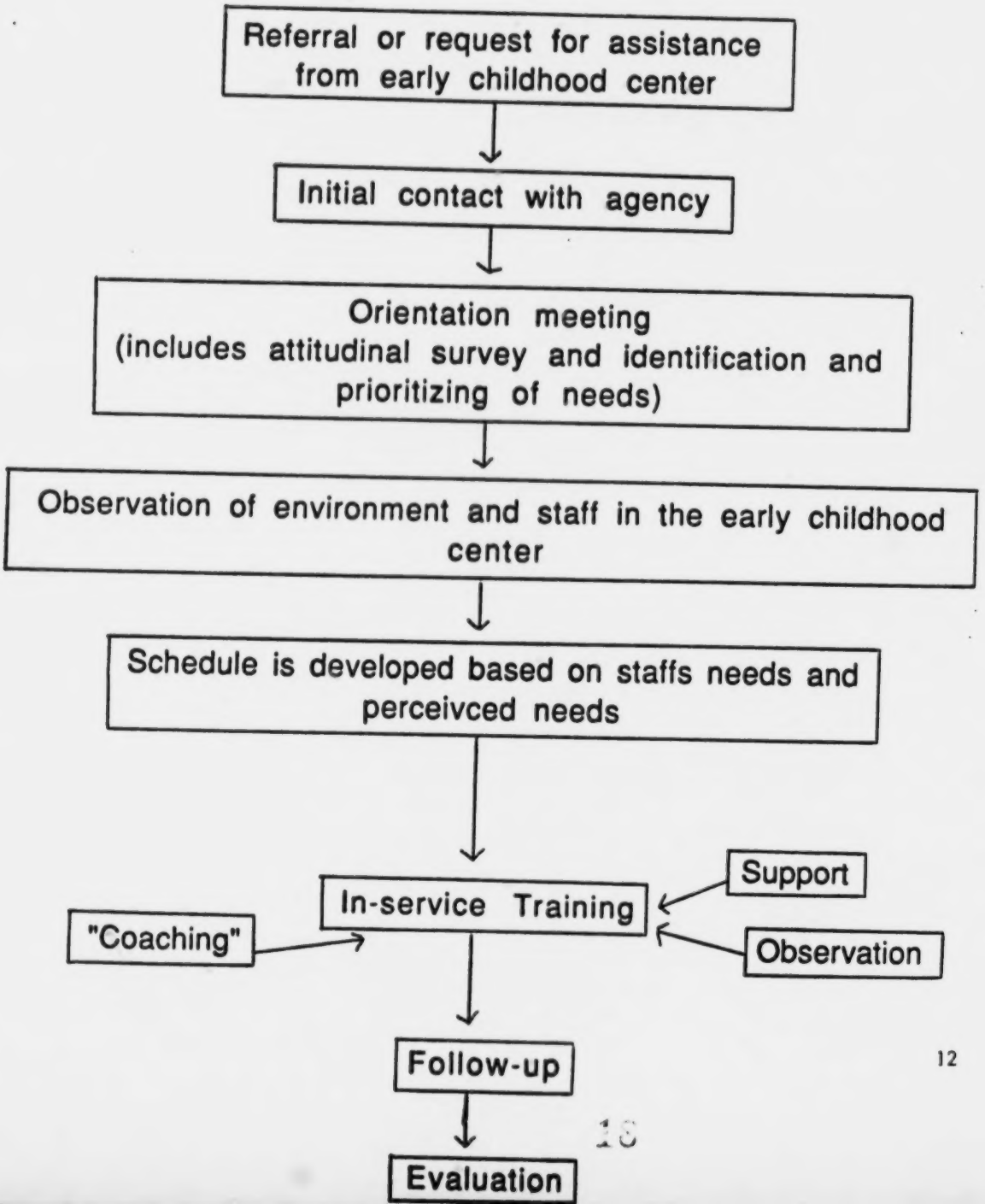
Project KIT: Kids in Transition, Educational Resource Book, Northern Trails AEA, Box M, Clear Lake, IA 50428, (515) 357-6125.

Follow-up:
When the in-services are completed, the attitudinal survey should be filled out again by each participant. The trainer needs to re-administer the environmental rating scale and observe each participant. Pre and post data can be summarized. On-going scheduled visits to the center should continue to reinforce skills and help with brainstorming specific problems.

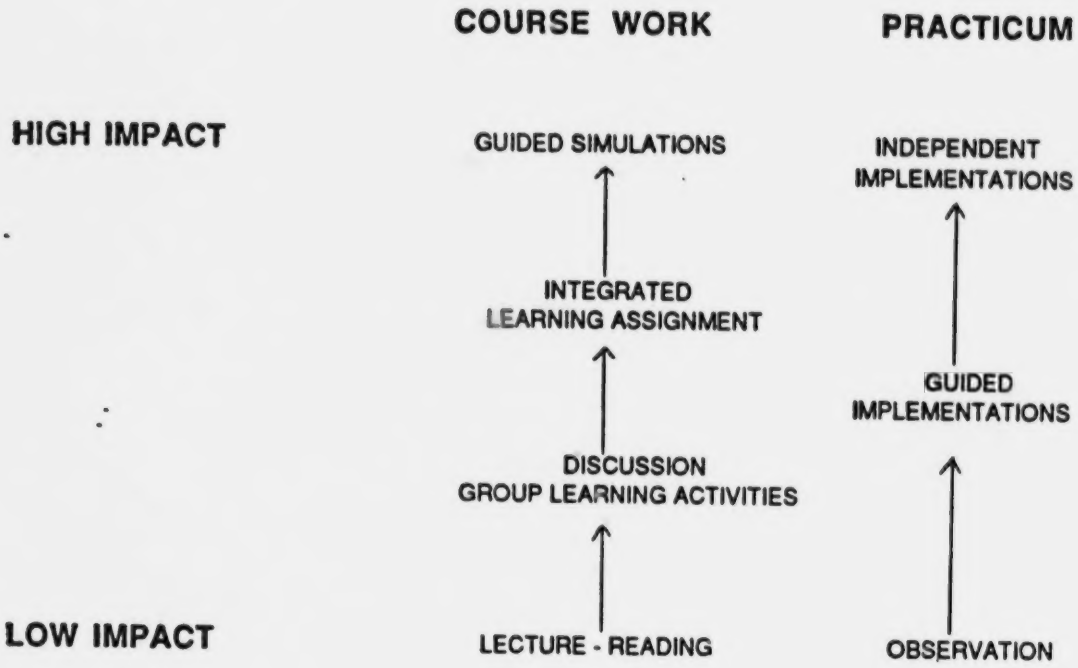
Evaluation:
Evaluation of the in-services should consist of a simple evaluation tool such as Figure A6, or a trainer-developed evaluation tool.

FIGURE 2

SERVICE DELIVERY MODEL FOR INSERVICE TRAINING FOR PRESCHOOL/DAY CARE PERSONNEL


Referral or request for assistance from early childhood center
Initial contact with agency
Orientation meeting (includes attitudinal survey and identification and prioritizing of needs)
Observation of environment and staff in the early childhood center
Schedule is developed based on staffs needs and perceivced needs
In-service Training
Support
Observation
"Coaching"
Follow-up
Evaluation

IN-SERVICE DELIVERY CONTINUUM



Adapted from: McCollum, 1982

FIGURE A1

(Your center's letterhead)

AUTHORIZATION FOR EXCHANGE OF INFORMATION

_____
(Name of Student)

I hereby grant permission for our agency, the Des Moines Public Schools, and the agencies or schools listed below (or authorized representatives of those agencies and schools) to exchange information related to the above student's management or education, which in their professional judgements may be of value in the continuing care and programming of this child. Such information will not contain sharing of the student's confidential record.

This portion should be filled out before parent/guardian signs.

_____ Name of Individual, Agency, School	_____ Name of Individual, Agency, School
_____ Professional Relationship	_____ Professional Relationship
_____ Street Address Phone	_____ Street Address Phone
_____ City State Zip	_____ City State Zip

_____ Name of Individual, Agency, School	_____ Name of Individual, Agency, School
_____ Professional Relationship	_____ Professional Relationship
_____ Street Address Phone	_____ Street Address Phone
_____ City State Zip	_____ City State Zip

Restrictions or Comments:

_____ Signature Date	_____ Staff Member requesting information Date
_____ Relationship to student	_____

FIGURE A2

PARENT CONFERENCE/CONTACT RECORD

STUDENT_____ DATES_____

SPECIAL CLASS TEACHER _____ PARENTS_____

REGULAR CLASS TEACHER_____ PARENT'S PHONE_____

SCHOOL_____ GRADE ____

DATE	TYPE OF CONTACT					PURPOSE	COMMENTS
	School	Home	Phone	Letter/ Note	Other		

FIGURE A3

DAY CARE/PRESCHOOL PERSONNEL QUESTIONNAIRE

Thank you in advance, for filling out this questionnaire. Please feel free to write comments as you go.

1. In what aspect do you currently serve young children?
   - ____ Teacher-preschool/day care
   - ____ Teacher assistant
   - ____ Director or administrator
   - ____ Early Childhood/Special Education Teacher
   - ____ Other _____

2. Check ( ) ages of the children you currently serve.
   ____ 0-2 years ____ 2-3 years ____ 4-5 years ____ 6-older

3. Do you presently or have you in the past served any handicapped children in your center?
   ____ Yes ____ No

   If yes:

   What handicapping condition(s) did he/she have?
   - ____ physically disabled
   - ____ mentally disabled
   - ____ visually impaired
   - ____ hearing impaired
   - ____ communication disorder
   - ____ behavior disorder

   If no:

   To your knowledge, have any handicapped children who have applied to your center been denied?
   ____ Yes ____ No

4. If the parent of a handicapped child applied to your center, would you consider enrolling the child?
   ____ Yes ____ No

   If yes:

   What handicapping conditions could your center accommodate?
   - ____ mentally disabled
   - ____ physically disabled
   - ____ communication disorder
   - ____ behavior disorder
   - ____ visually impaired
   - ____ hearing impaired

5. What workshops or inservices would you find most helpful if they were offered to your center free of charge? Identify **four** items below that are your highest priority by placing a X mark in the space provided.
   - ____ How to manage a child's behavior within the classroom.
   - ____ How to teach social skills (for example, requesting things appropriately, playing nicely with other children, etc.)
   - ____ Ideas in providing a wide range of stimulating experiences.
   - ____ Ideas for working on a specific need (for example, language, speech, physical therapy exercises, fine motor activities).
   - ____ How to make referrals to special education programs.
   - ____ Kinds of special education programs available for preschool children.
   - ____ How to teach self-help skills (eating, toileting, dressing).
   - ____ Developing a behavior management system in an informal setting.
   - ____ Child development and how it relates to the activities, environment, and expectations we have of children.
   - ____ Dealing with a difficult child in a large group.
   - ____ The high risk child-what environments and activities work for the "at-risk" child (children who come from low income, premature, disrupted families).

Optional: Please fill in the following section if you feel comfortable.

Name_____ Center/School_____
Address_____ City_____

QUESTIONNAIRE
INTEGRATING HANDICAPPED CHILDREN

Program or Agency _____
Pre/Post

Background Information

1. Indicate your age range:
   a) under 20 b) 20-25 c) 26-35 d) 26-45 e) 46 and over

2. Number of years of experience as a teacher or assistant:
   a) 1-2 b) 3-5 c) 6 or more

3. How much contact have you had with handicapped children in a non-teaching capacity?
   a) none b) some c) often

4. How much contact have you had with handicapped children in a teaching capacity?
   a) none b) some c) often

5. Estimate your comfort level with handicapped children:
   a) comfortable b) unsure c) uncomfortable

6. How much have you interacted with a parent of a handicapped youngster in a teaching capacity?
   a) none b) some c) often

7. How much have you interacted with a parent of a handicapped youngster in a non-teaching capacity?
   a) none b) some c) often

8. Have parents of handicapped young children ever approached you requesting placement of their children in your day care center?
   a) never b) sometimes c) often

1 - Strongly Agree
2 - Agree
3 - Agree Somewhat
4 - Disagree
5 - Strongly Disagree

1.	Many of the things teachers do with regular children in a preschool are appropriate for special-needs children.	1	2	3	4	5
2.	The needs of handicapped children can best be served through special, separate preschools.	1	2	3	4	5
3.	A special-needs child's preschool behavior generally requires more patience from the teacher than does the behavior of the normal child.	1	2	3	4	5
4.	The challenge of being in a regular preschool will promote the academic growth of the special-needs child.	1	2	3	4	5
5.	The extra attention special-needs children require will be to the detriment of the other children.	1	2	3	4	5
6.	Mainstreaming offers mixed group interaction which will foster understanding and acceptance of differences.	1	2	3	4	5
7.	It is difficult to maintain order in a regular preschool that contains a special-needs child.	1	2	3	4	5
8.	The behavior of special-needs children will set a bad example for the other children.	1	2	3	4	5
9.	Isolation in a special preschool has a negative effect on the social and emotional development of a special-needs child.	1	2	3	4	5
10.	The special-needs child will probably develop academic skills more rapidly in a special preschool than in a regular preschool.	1	2	3	4	5
11.	Integration of special-needs children will require significant changes in regular preschool procedures.	1	2	3	4	5
12.	Most special-needs children are well behaved in the preschool.	1	2	3	4	5
13.	The contact regular-class children have with mainstreamed children may be harmful.	1	2	3	4	5
14.	Special-needs children will monopolize the teacher's time.	1	2	3	4	5
15.	Mainstreaming the special-needs child will promote his/her social independence.	1	2	3	4	5
16.	It is likely that a special-needs child will exhibit behavior problems in a regular preschool setting.	1	2	3	4	5
17.	The integration of special-needs children can be beneficial for regular children.	1	2	3	4	5

1 - Strongly Agree
2 - Agree
3 - Agree Somewhat
4 - Disagree
5 - Strongly Disagree

18. Special-needs children need to be told exactly what to do and how to do it.	1	2	3	4	5
19. It is likely that a special-needs child will exhibit behavior problems in a regular preschool setting.	1	2	3	4	5
20. The integration of special-needs children can be beneficial for regular children.	1	2	3	4	5
21. Special-needs children need to be told exactly what to do and how to do it.	1	2	3	4	5
22. Mainstreaming is likely to have a negative effect on the emotional development of the special-needs child.	1	2	3	4	5
23. Increased freedom in the preschool creates too much confusion.	1	2	3	4	5
24. The special-needs child will be socially isolated by regular preschool children.	1	2	3	4	5
25. Parents of a special-needs child present no greater problem for a preschool teacher than those of a normal child.	1	2	3	4	5
26. Integration of special-needs children will necessitate retraining of regular staff.	1	2	3	4	5
27. Special-needs children should be given every opportunity to function in the regular-preschool setting, where possible.	1	2	3	4	5
28. Special-needs children are likely to create confusion in the regular preschool.	1	2	3	4	5
29. The presence of special-needs children will promote acceptance of differences on the part of regular children.	1	2	3	4	5

Adapted from Larrivee and Cook (1979). Mainstreaming: A study of variables of affecting teacher attitude. Journal of Special Education, 13. 315-324.

FIGURE A5

OBSERVATION RATING SCALE FOR TEACHER BEHAVIORS

Teacher _____ Center _____

Observer _____

The underlined letters are the code for the behaviors described. Use information from script-tape to rate observation of teachers' behaviors.

		Observed	Not Observed	NA
I.	Instructional Presentation			
	a. Teacher begins with activity or statement that focuses children's attention.	------	------	------
	b. Teacher presents the lesson in language understandable to the students.	------	------	------
	c. Teacher provides relevant examples and demonstrations.	------	------	------
	d. Teacher plans activities that students handle with a high rate of success.	------	------	------
	e. Teacher asks questions that students handle with a high rate of success.	------	------	------
	f. Teacher conducts the lesson at a brisk pace.	------	------	------
	g. Teacher makes transitions between activities efficiently.	------	------	------
	h. Teacher makes sure the activity is clear.	------	------	------
	i. Teacher summarizes the main points of the lesson when it is complete.	------	------	------
II.	Management of Instructional Time			
	a. Teacher has materials, supplies, and equipment ready at the start of each lesson.	------	------	------
	b. Teacher gets the class started quickly.	------	------	------
	c. Teacher gets the students on-task quickly.	------	------	------
	d. Teacher maintains a high level of student time-on-task.	------	------	------
III.	Management of Student Behavior			
	a. Teacher has established routine procedures that govern routine administrative matters.	------	------	------
	b. Teacher has established routine procedures that govern students verbal participation in class activities.	------	------	------
	c. Teacher has established a routine procedure that governs student movement in the classroom.	------	------	------
	d. Teacher frequently monitors the behavior of all students.	------	------	------
IV.	Instructional Monitoring			
	a. Teacher circulates during activities to reinforce and encourage children.	------	------	------
	b. Children are supervised well.	------	------	------
V.	Instructional Feedback			
	a. Teacher provides feedback on appropriateness of students' responses and behavior.	------	------	------
	b. Teacher provides feedback promptly.	------	------	------
	c. Teacher affirms correct oral responses and moves on.	------	------	------
	d. Teacher provides helpful feedback after incorrect responses.	------	------	------

Adapted from the Carolina Teaching Performance System (Wyne, M.D., White, K.P., Stuck, G.B., & Coop, R.H., 1985).

FIGURE A6

IN-SERVICE EVALUATION INTEGRATING HANDICAPPED CHILDREN INTO EARLY CHILDHOOD SETTINGS

DATE _____

LOCATION _____

TEACHER(S) _____

_____

_____

Overall the course was: __ Excellent __ Good __ Fair __ Poor

1 - Strongly Agree
2 - Agree
3 - Somewhat
4 - Disagree
5 - Strongly Disagree

WORKSHOP CONTENT

1.	I think the information presented in this course will help me in working with handicapped and delayed children in a day care and preschool.	1 2 3 4 5
2.	The methods used (group experiences, worksheets, lecture, brainstorming) were helpful for increasing my knowledge and understanding of the material.	1 2 3 4 5
3.	The format and organization of this workshop was appropriate.	1 2 3 4 5
4.	The handouts were useful as an instructional aid.	1 2 3 4 5
5.	I would recommend another day care or preschool teacher to attend a course like this.	1 2 3 4 5

Adapted from: "Mainstreaming Children with Handicaps in Day Care and Preschool," by Anne Booth et al.

FIGURE A7

EARLY CHILDHOOD CONTACT FORM

Name	Date														

CODE:
O - Observation
I - Inservice
P - Phone Contact

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PLANNING

AND

INTRODUCTION SESSIONS

INTRODUCTION AND PLANNING SESSION SUGGESTED OUTLINE

OBJECTIVES	OUTLINE OF ACTIVITIES
Participants will:	
1. Complete an attitudinal survey (See Figure 1)	1.1 After introductions, review the focus of the program and your reasons for being with them. (Handout P1 can be reviewed.) 1.2 Review agenda for the present session (i.e., planning, giving basic information on integration, etc.) 1.3 Handout attitudinal survey (Figure P1). It should take about 10 minutes to complete. Collect and keep to compare to the final survey that is given at the last session. 1.4 Leave needs assessment (Figure P2) with director along with instructions to distribute to staff members who are participating in the in-service and return needs assessment within the week. (Leave large envelope with return address and postage).
2. Receive general information regarding integration (See Figure 2).	2.1 Review purpose of providing opportunities for handicapped and non-handicapped children in the same environment. Use handout, "What is Integration?" as a guide/or handout. (Handout P2)
3. Participate in planning of the in-services for the future	3.1 Read Activity #1 "Planning for the In-services" and complete. 3.2 The "In-service Planning Sheet" (Figure P3) can be used to organize and plan what will be presented or planned for each in-service time, and what the activities will be (See example Figure P4). This should be completed after leaving the meeting and a copy along with a letter should be sent to each participant.

4. Be observed by trainee a minimum of 1 hour.

4.1 Before leaving the first session, explain you will be visiting each class for approximately 1 hour before the next meeting.

4.2 The Early Childhood Environmental Rating Scale (ECERS) is an excellent tool for the trainer to use during the visits. (ECERS in appendices) The results should be summarized and compared to the post observation at the end of the year. A teacher observation should be completed by trainer (Similar to Carolina Teaching Performance Tool, Figure P5).

4.3 The trainer should not only use the observation time for formal observation, but should also use this time to begin building rapport with participants.

* Keep results in a folder with "Record of Contact" and other forms labeled with center name.

QUESTIONNAIRE
INTEGRATING HANDICAPPED CHILDREN

Program or Agency _____
Pre/Post

Background Information

1. Indicate your age range:
   a) under 20 b) 20-25 c) 26-35 d) 26-45 e) 46 and over

2. Number of years of experience as a teacher or assistant:
   a) 1-2 b) 3-5 c) 6 or more

3. How much contact have you had with handicapped children in a non-teaching capacity?
   a) none b) some c) often

4. How much contact have you had with handicapped children in a teaching capacity?
   a) none b) some c) often

5. Estimate your comfort level with handicapped children:
   a) comfortable b) unsure c) uncomfortable

6. How much have you interacted with a parent of a handicapped youngster in a teaching capacity?
   a) none b) some c) often

7. How much have you interacted with a parent of a handicapped youngster in a non-teaching capacity?
   a) none b) some c) often

8. Have parents of handicapped young children ever approached you requesting placement of their children in your day care center?
   a) never b) sometimes c) often

1 - Strongly Agree
2 - Agree
3 - Agree Somewhat
4 - Disagree
5 - Strongly Disagree

1.	Many of the things teachers do with regular children in a preschool are appropriate for special-needs children.	1	2	3	4	5
2.	The needs of handicapped children can best be served through special, separate preschools.	1	2	3	4	5
3.	A special-needs child's preschool behavior generally requires more patience from the teacher than does the behavior of the normal child.	1	2	3	4	5
4.	The challenge of being in a regular preschool will promote the academic growth of the special-needs child.	1	2	3	4	5
5.	The extra attention special-needs children require will be to the detriment of the other children.	1	2	3	4	5
6.	Mainstreaming offers mixed group interaction which will foster understanding and acceptance of differences.	1	2	3	4	5
7.	It is difficult to maintain order in a regular preschool that contains a special-needs child.	1	2	3	4	5
8.	The behavior of special-needs children will set a bad example for the other children.	1	2	3	4	5
9.	Isolation in a special preschool has a negative effect on the social and emotional development of a special-needs child.	1	2	3	4	5
10.	The special-needs child will probably develop academic skills more rapidly in a special preschool than in a regular preschool.	1	2	3	4	5
11.	Integration of special-needs children will require significant changes in regular preschool procedures.	1	2	3	4	5
12.	Most special-needs children are well behaved in the preschool.	1	2	3	4	5
13.	The contact regular-class children have with mainstreamed children may be harmful.	1	2	3	4	5
14.	Special-needs children will monopolize the teacher's time.	1	2	3	4	5
15.	Mainstreaming the special-needs child will promote his/her social independence.	1	2	3	4	5
16.	It is likely that a special-needs child will exhibit behavior problems in a regular preschool setting.	1	2	3	4	5
17.	The integration of special-needs children can be beneficial for regular children.	1	2	3	4	5

1 - Strongly Agree
2 - Agree
3 - Agree Somewhat
4 - Disagree
5 - Strongly Disagree

18. Special-needs children need to be told exactly what to do and how to do it. 1 2 3 4 5

19. It is likely that a special-needs child will exhibit behavior problems in a regular preschool setting. 1 2 3 4 5

20. The integration of special-needs children can be beneficial for regular children. 1 2 3 4 5

21. Special-needs children need to be told exactly what to do and how to do it. 1 2 3 4 5

22. Mainstreaming is likely to have a negative effect on the emotional development of the special-needs child. 1 2 3 4 5

23. Increased freedom in the preschool creates too much confusion. 1 2 3 4 5

24. The special-needs child will be socially isolated by regular preschool children. 1 2 3 4 5

25. Parents of a special-needs child present no greater problem for a preschool teacher than those of a normal child. 1 2 3 4 5

26. Integration of special-needs children will necessitate retraining of regular staff. 1 2 3 4 5

27. Special-needs children should be given every opportunity to function in the regular-preschool setting, where possible. 1 2 3 4 5

28. Special-needs children are likely to create confusion in the regular preschool. 1 2 3 4 5

29. The presence of special-needs children will promote acceptance of differences on the part of regular children. 1 2 3 4 5

Adapted from Larrivee and Cook (1979). Mainstreaming: A study of variables of affecting teacher attitude. Journal of Special Education, 13, 315-324.

FIGURE P2

DAY CARE/PRESCHOOL PERSONNEL QUESTIONNAIRE

Thank you in advance, for filling out this questionnaire. Please feel free to write comments as you go.

1. In what aspect do you currently serve young children?
   - _____ Teacher-preschool/day care
   - _____ Teacher assistant
   - _____ Director or administrator
   - _____ Early Childhood/Special Education Teacher
   - _____ Other _____

2. Check (✓) ages of the children you currently serve.
   _____ 0-2 years _____ 2-3 years _____ 4-5 years _____ 6-older

3. Do you presently or have you in the past served any handicapped children in your center?
   _____ Yes _____ No

   If yes: What handicapping condition(s) did he/she have?
   - _____ physically disabled
   - _____ mentally disabled
   - _____ visually impaired
   - _____ hearing impaired
   - _____ communication disorder
   - _____ behavior disorder

   If no: To your knowledge, have any handicapped children who have applied to your center been denied?
   _____Yes _____ No

4. If the parent of a handicapped child applied to your center, would you consider enrolling the child?
   _____ Yes _____ No

   If yes: What handicapping conditions could your center accommodate?
   - _____ mentally disabled
   - _____ physically disabled
   - _____ communication disorder
   - _____ behavior disorder
   - _____ visually impaired
   - _____ hearing impaired

5. What workshops or in-services would you find most helpful if they were offered to your center free of charge? Identify **four** items below that are your highest priority by placing a ✓ mark in the space provided.
   - _____ How to manage a child's behavior within the classroom.
   - _____ How to teach social skills (for example, requesting things appropriately, playing nicely with other children, etc.).
   - _____ Ideas in providing a wide range of stimulating experiences.
   - _____ Ideas for working on a specific need (for example, language, speech, physical therapy exercises, fine motor activities).
   - _____ How to make referrals to special education programs.
   - _____ Kinds of special education programs available for preschool children.
   - _____ How to teach self-help skills (eating, toileting, dressing).
   - _____ Developing a behavior management system in an informal setting.
   - _____ Child development and how it relates to activities, environment, and expectations we have of children.
   - _____ Dealing with a difficult child in a large group.
   - _____ The high risk child -- what environments and activities work for the "at-risk" child (children who come from low income, premature, disrupted families).

Optional: Please fill in the following section if you feel comfortable.

Name _____ Center/School _____
Address _____ City_____

FIGURE P3

IN-SERVICE PLANNING SHEET

EARLY CHILDHOOD CENTER _____

Dates of In-Service:

Topic: Activities:	Topic: Activities:	Topic: Activities:	Topic: Activities:	Topic: Activities:

Dates of In-Service:

Topic: Activities:	Topic: Activities:	Topic: Activities:	Topic: Activities:	Topic: Activities:

FIGURE P4

IN-SERVICE PLANNING SHEET

EARLY CHILDHOOD CENTER Woodland Daycare

Dates of In-Service:

March 1	March 8	March 29	April 4	April 18
Topic: Special Education Issues	**Topic:** Dealing with Parents	**Topic:** Introduction to discipline	**Topic:** Examining behavior management techniques and ideas	**Topic:** Setting up a behavior management plan
Activities: 1. Referral Procedures 2. Staffings 3. IEP Show example	**Activities:** Social worker from program will present informally 1. Communication strategies with parents of handicapped and other handicapped children. 2. Tips for working with parents	**Activities:** 1. Review Antecedent factors & behaviors a. environment review & movement Rating Scale b. Child's day type c. Teacher skills	**Activities:** 1. Review teaching strategies 2. Review general behavior management techniques 3 Review "Young & Special" video on behavior management	**Activities:** 1. Steps in Evaluating effectiveness of behavior management plan 2. Individual teaching Arrangements

Dates of In-Service:

May 2	May 9	May 16		
Topic: Intro to general handicapping conditions	**Topic:** Tips for working with handicap children	**Topic:** Making materials	**Topic:** Wrapping it up	**Topic:**
Activities: 1. Discuss general objectives for handicapped children 2. Review handouts on handicapping conditions 3 View video tape "Young & Special" & handicapping need.	**Activities:** 1. Pinpoint area of interest (related to children at center) 2. General discussion 3 Develop list of things they would like to make/use at work.	**Activities:** 1. Buy & gather center to laminate and make materials.	**Activities:** 1. Attitudinal Survey 2. Evaluation 3. Tests.	**Activities:**

SPECIAL EDUCATION STAFFING

What is a staffing?

A special education staffing is a meeting held to decide whether or not a child has special needs and, if so, to plan the services to meet these needs.

What will happen?

Each person in attendance will be introduced and the order of events will be reviewed by the chairperson. During the meeting you, as the early childhood teacher, will be given an opportunity to report how the child does in a normal setting. It is suggested that a brief review of the child's strengths be discussed, followed by areas of difficulty or concerns. It is appropriate to ask questions during the meeting.

Who will be there?

Core team members.

1. Parents - the staffing is usually held at a time that is most convenient to the parent. The parent(s) are considered an important part of the team and are encouraged to ask questions and share information.
2. Chairperson - the chairperson is usually the principal or a representative (i.e. consultant) and is responsible for making the meeting run smoother.
3. Teacher - the teacher is responsible for providing information related to the child's daily progress. This information may include tests, examples of work and description of behavior. Much of the report will include reference to the child's classroom performance.
4. Others may attend also; usually at the discretion of the teacher, parent or principal. Usually anyone who has worked directly with the child or who has test results to report.

What happens after the staffing?

If the child is found to have special needs, a special education team will discuss options for placement in a special education program. The child may continue in a regular setting and receive special education too. If the normal setting is felt by the team to be detrimental, it may be recommended the child receive only special education at this time.

In addition to identifying placement the Individualized Education Plan (IEP) will be written and include instructional goals and any special teaching methods, transportation or equipment.

FIGURE P5

OBSERVATION RATING SCALE FOR TEACHER BEHAVIORS

Teacher _____ Center _____

Observer _____

The underlined letters are the code for the behaviors described. Use information from script-tape to rate observation of teachers' behaviors.

	Observed	Not Observed	NA
I. Instructional Presentation			
a. Teacher begins with activity or statement that focuses children's attention.	------	------	------
b. Teacher presents the lesson in language understandable to the students.	------	------	------
c. Teacher provides relevant examples and demonstrations.	------	------	------
d. Teacher plans activities that students handle with a high rate of success.	------	------	------
e. Teacher asks questions that students handle with a high rate of success.	------	------	------
f. Teacher conducts the lesson at a brisk pace.	------	------	------
g. Teacher makes transitions between activities efficiently.	------	------	------
h. Teacher makes sure the activity is clear.	------	------	------
i. Teacher summarizes the main points of the lesson when it is complete.	------	------	------
II. Management of Instructional Time			
a. Teacher has materials, supplies, and equipment ready at the start of each lesson.	------	------	------
b. Teacher gets the class started quickly.	------	------	------
c. Teacher gets the students on-task quickly.	------	------	------
d. Teacher maintains a high level of student time-on-task.	------	------	------
III. Management of Student Behavior			
a. Teacher has established routine procedures that govern routine administrative matters.	------	------	------
b. Teacher has established routine procedures that govern students verbal participation in class activities.	------	------	------
c. Teacher has established a routine procedure that governs student movement in the classroom.	------	------	------
d. Teacher frequently monitors the behavior of all students.	------	------	------
IV. Instructional Monitoring			
a. Teacher circulates during activities to reinforce and encourage children.	------	------	------
b. Children are supervised well.	------	------	------
V. Instructional Feedback			
a. Teacher provides feedback on appropriateness of students' responses and behavior.	------	------	------
b. Teacher provides feedback promptly.	------	------	------
c. Teacher affirms correct oral responses and moves on.	------	------	------
d. Teacher provides helpful feedback after incorrect responses.	------	------	------

Adapted from the Carolina Teaching Performance System (Wyne, M.D., White, K.P., Stuck, G.B., & Coop, R.H., 1985).

USING A TEACHER CONSULTANT

Who do I call?

Area Education Agencies or local districts who serve preschool special education students can sometimes offer assistance to centers who have a handicapped child enrolled. Each education agency may offer different services so it is best to call the local district or area education agency and ask for the early childhood special education program.
Some programs may have a specific person responsible for assisting children in regular preschools. Others may have a home intervention teacher that visits handicapped children at home or at a day care and can assist preschool personnel with specific questions. Still other areas have "strategists" who will assist centers to integrate a disabled child.

Purpose of a Teacher Consultant in a regular preschool/ day care

The purpose of a teacher consultant who visits a regular preschool center is to provide services that will increase skills and to assist in the problem solving process with the staff that directly serves the handicapped child.

What to expect

A consultation may provide any of the following services:

- Observation
- Demonstration teaching
- In-service training
- Feedback
- "Teaming" process skills
- Coordination of other services
- Support
- Researching a question
- Information on referral

Again, it depends on each individual education area and their guidelines for the position. It never hurts to ask if your center could get assistance in any of the areas listed above.

What not to expect

A consultant/teacher would not:

- provide child care
- supervise
- discipline
- make decisions
- "fix" all problems

What the consultant and staff need to do

1. Meet regarding expectations and role the consultant/teacher will play.
2. Get parental permission when any matter concerns individual children. Use a simple permission form (See appendix) to obtain permission for observation and consultation between the school and preschool center.
3. Maintain written record of contact. A simple form to write down what was done with the individual center or what kind of service was delivered. Keep it simple.
4. Don't be afraid to call the contact person (consultant/teacher) when your center needs help.
5. Remember solving problems takes time. Share information honestly and regularly.

WHAT IS INTEGRATION?

INTEGRATION - The word Integration is used when referring to giving handicapped and non-handicapped children opportunities to play, learn and interact together.

What are the advantages?

To non-disabled children

- Opportunities to interact with children who are disabled.
- Opportunities to be leaders.
- Form friendships with children who are disabled.
- Preschool children do not generally detect differences between children. So unless the disabled child has some special equipment or physically looks different they may view them as "just another child."

To disabled children

- Learn age appropriate social and play skills with guidance.
- Have the opportunity to be with children who are talking, playing, and working like preschool children.
- A challenging environment that encourages them to be independent.
- Opportunity to develop a more positive image because they are doing what other children do.

Myths about integrating children:

- Children do not magically interact -- Because the two groups are together does not insure the two groups will play together. Special instruction can be very successful in encouraging the non-disabled children to interact (i.e. placing a disabled child at the same table as non-disabled children, modeling how to ask someone to play, etc.)

- Non-disabled children usually do not imitate inappropriate behaviors that a disabled child may exhibit. If they do, it will not continue unless it is reinforced by an adult.

- Children with disablilities do not automatically imitate their non-disabled peers. Actually teaching them, as with any skill, will help them to learn.

- Rejection of the disabled child is rare. Preschool children tend to be sensitive to the needs of others and will generally model how they see the adults interacting with the disabled child.

- The handicapped child does not tend to take any more teacher time than the other children. In fact, encouraging independence is usually an important goal with handicapped children.

What is important when integrating handicapped children?

- Probably the same kinds of things that are important for any preschool child:

  - Promoting self esteem, independence, play skills, getting along with others and following directions.

ACTIVITY #1
TIME ALLOWANCE 30 MIN.

PLANNING FOR THE IN-SERVICES

PROCEDURE

1. Review purpose(s) of the in-services (i.e. "To provide regular preschool staff with the tools to integrate handicapped children successfully).

2. After passing out paper and pencils to each participant, ask the group to brainstorm (for the next 5 minutes) any ideas of things the group could do during the in-service times that are scheduled. Suggest some ideas, i.e. dealing with behavior problems, parents, time to make materials, visits to child's special education program, etc. Limit the number of suggestions, as you want the group to come up with ideas on their own.

3. After giving the group 5 minutes -- ask a member of the group to serve as recorder (have them record ideas on large sheets of paper taped to the walls).

4. Ask each member of the group to share, one-by-one, an idea. Going around the circle and calling on each member to share is suggested. Repeat this process until each member has shared all of their ideas. This time is to be used for sharing ideas, <u>not</u> for critiquing the ideas.

5. Ask two members of the group to record each idea on an individual 3x5 card.

6. Instruct group to work as a group and decide by consensus if an idea is (a) a high priority, (b) a minimum priority, (c) a low priority.

   Some of the ideas could be considered similar, those may be combined.

7. When the group has completed the task, explain that the high and some of the medium ideas (depending on the number of ideas and in-services planned) will be used to develop a schedule (See Figure P2).

MATERIALS

Paper
Pencils
3x5 cards

The group should be no larger than 6-7. If it is larger, divide the group into smaller groups and give each group a set of ideas written on 3x5 cards.

Give the group 5 minutes to accomplish this task.

Only 20% should be in the "high" category, 50% in the medium, and 30% in the low category. (Figure the number out before giving instructions.)

Mark each area on the table or floor in front of them with "High," "Medium," or "Low."

PREPARING AN ENVIRONMENT FOR A YOUNG CHILD WITH SPECIAL NEEDS

PREPARING AN ENVIRONMENT FOR A YOUNG CHILD WITH SPECIAL NEEDS

SUGGESTED OUTLINE

OBJECTIVES	OUTLINE OF ACTIVITIES
Participants will:	
1. Become familiar with general strategies to make a smooth transition for staff and new child.	1.1 Review specific child information and discuss child that will be coming to their center. This may be done with the child's parents and perhaps with a therapist who has worked directly with the child (i.e., occupational therapist, speech clinician). If parent is not included make sure a "Release of Information" has been signed by the parent. The information sheet can be filled out with the parent and special education teacher prior to the meeting (Figure E1). 1.2 Review "He's Coming! He's Coming!" (Handout E1). Brainstorm ideas for making transitions for new child(ren). 1.3 View video "Not in My Classroom" a Young and Special video tape (Appendix - Resources for information). 1.4 Use Q-Sort activity as an optional activity for a large group. A discussion can follow regarding similarities of programs with handicapped children and those serving preschool children.
2. Know how to respond to children's and parent's questions regarding the child with a handicapping condition.	2.1 Review handout E2 and/or E3 dealing with"Knowing What to Say." Questions regarding adult questions can be discussed using Handout E5. 2.2 Complete Activity E1 "It's All in What You Say".

PREPARING AN ENVIRONMENT FOR A HANDICAPPED CHILD

This section will give participants information and practice on dealing with non-handicapped children's and parents' questions. It does not outline transition procedures. Special education personnel can receive information regarding this process from these excellent sources:

Project Mainstream
Extended Day Care Project
Two West Mifflin Street
Madison, Wisconsin 537-3

Project STIP
Department of Special Education
241 Oneida Avenue, Room 80
San Francisco, CA 94112

"Transition from Preschool to Kindergarten"
Chapel Hill Training - Outreach Project
Lincoln Center
Merrit Mill Rd.
Chapel Hill, N.C. 27514

Project K.I.T.
Kids in Transition, Educators Resource Book
Northern Trails Area Education Agency
Division of Special Education
Early Childhood Special Education
Box M
Clear Lake, IA 50428

"Not in My Class", Young and Special Video Tapes
Electro Systems, Inc.
5400 Wilshire Drive.
Columbus, Ohio 43232

FIGURE E1

CHILD INFORMATION SHEET

Child's Name _____

Parent(s) Name _____ Phone # _____

Special Education Attendence Center _____

Special Education Teacher _____

Telephone # _____

Child's Strengths _____

_____

_____

_____

Adaptions _____

_____

_____

Goals and Objectives Appropriate for Preschool Setting _____

_____

_____

_____

Comments _____

_____

_____

INTEGRATION QUESTIONS THAT REGULAR EDUCATORS MAY HAVE

Staff members may have questions regarding how to deal with questions the non-handicapped children and their parents may have.

In general the literature indicates that integrating handicapped and non-handicapped children has positive benefits for both groups. It has also been found that parents of non-handicapped children, in general, feel that integration is a positive opportunity for their child.

The following two handouts are appropriate for an introduction to in-service. Especially to groups or individuals that have specific questions about dealing with children's and parents' questions.

HE'S COMING, HE'S COMING!

How do I prepare the other children?

1. It is not necessary to make a "big deal" of telling the other children about a handicapped child coming to your class. Emphasize the ways that the handicapped child is the same as they are.
2. Keep explanations simple. If the child has special equipment (wheel chair, cane, crutches) a simple explanation such as "B.J. uses the crutches to help him walk" is sufficient.

What should I do before the child comes?

1. Meet with the parents. Ask the parents what their expectations are and tell them what your expectations are for the whole class (i.e. "We emphasize getting along with others, having fun, being as independent as possible, etc.")
2. Ask the parents what their child's strengths and weaknesses are. Discuss any periods of the day that might be difficult for their child.
3. Invite parents and child to visit the center when there aren't any children so the child can become familiar with the setting. Talk about the other children who attend.
4. Ask for information about the child and his/her specific disability.

The child's here, now what do I do?

1. The first day, assign a child to show the new child around.
2. Let the parents know some of the positive things that happen during the day.
3. If you're concerned about a problem, talk to the parents about it in a matter-of-fact fashion. Let them know what you're doing and ask them for suggestions.
4. Be careful not be be over protective. Your goal should be to provide experiences the child can do without frustration.
5. Ask for help from the special education program if you need it.
6. Reinforce small steps toward a bigger goal. When the child attempts to do something that may be difficult, praise the attempt.
7. Getting along with others and following the rules is an important objective. Learning to adjust to the group would be an important goal for a disabled child.

KNOW WHAT TO SAY

There is sometimes concern about how the non-handicapped children (and sometimes their parents) will accept the presence of a handicapped child.

Questions:

- Is it necessary to inform the parents of the non-handicapped children regarding the arrival of a handicapped child?	- Not necessarily. Actually, the literature does not indicate parents of non-handicapped children are very concerned about having a handicapped child in the same environment. Use your own judgement, but in general a handicapped child should be treated the same as any child who is enrolled.
- Should the teacher prepare the other children in the class about a handicapped child who will be attending?	- This may not be necessary either. Preschool children do not notice differences in people unless the differences are obvious. If you feel preparation isn't necessary because of obvious visual differences, show the children a picture and talk matter-of-factly about why the child is, i.e., missing a limb etc. It is important to emphasize how the children are the same. This can be done by showing the other children a favorite toy, or showing some of the things the handicapped child likes to do.
- Should special accommodations be made in the classroom to meet the handicapped child's needs?	- Try to involve the child in as many activities as possible that the other children are doing. A school consultant or a school therapist may be able to help with suggestions for specific times of the day.

Children often have questions and make comments about differences between themselves and others.

Remember that children:

- Are naturally curious
- Think in concrete terms rather than abstract terms
- Begin to categorize and discriminate
- Perceptions are based on what the child can actually see and not on abstract reasoning
- React on their emotions rather than in a logical way
- Are beginning to learn some "social skills"
- Are influenced by the attitudes of the significant adults in their lives

When children ask questions regarding other children, consider the following points:

* Remember that the attitude you convey in your discussion is as important as the content.

* Be brief and factual.

* Give the child undivided attention and observe his/her response.

* Show interest in the question or comment.

* Use simple concrete words and metaphors the child understands.

* Be respectful of the child's comments or questions. Laughing, shaming or interrupting may discourage more questions.

* Avoid arguments or dogmatic statements. Simply state what you know or think.

* Be empathic. Restate what the child said but in different terms. Try to understand and identify with the child's concerns.

* Be sure your content and attitude are consistent. Laughing at a child's clever, though rude, remark as you reprimand him/her gives a mixed message.

* Consider underlying thoughts and feelings as well as the content of the child's questions.

* Look at the handicapped child's ability to respond on his own:
  - The child may need some adult help in responding.
  - Adults need to respect the child's ability and need to answer on her own.

Remember that children emulate what adults model.

Respond to the child's comment or question with an example that is relevant to their own experience, i.e., "When you were younger you needed to help using the bathroom too."

WHAT TO SAY

Possible	Adult Responses	Adaptions
1. "Why does he go with that lady." OR "Why is that lady here?"	Explain the child is: "Learning to talk (walk, draw) better." OR "He's working on his walking (or talking, etc.)."	1. It is generally a good idea to have the therapist stay in the room and work the therapy into the daily routine or work with the child in the room. Non-handicapped children can see what is actually happening when "that lady" comes. 2. Greet (along with the children) the therapist when he/she arrives. The "guest" will not be such a "mystery." 3. If the therapist works with the child outside the room, have the handicapped child choose a peer to go with him. (This should be cleared with the therapist before hand.)
2. "How come she doesn't say anything when I talk to her?"	Encourage non-handicapped peer to try again. Direct child to call handicapped child's name until she looks at her then direct the non-handicapped child to make the comment again, e.g., "Susan, Susan (child looks) want to play with me?" If Susan smiles, indicate to non-handicapped child that that means yes.	The non-handicapped peers need to be taught they have to get eye contact before they ask the question. If handicapped child does not talk, show peer the "signs" the handicapped peer uses to indicate yes or no.
3. "He talks funny."	Respond with a reflective listening statement, e.g., "You're having trouble understanding him?" Model to child what you do when you can't understand him, e.g., "You want the truck?" OR "Say it again." Reply with a simple response, i.e., "She was born that way. The braces help support her legs so she can do lots of the same things you can do and the braces help her."	It is important to teach non-handicapped children "how to" respond. Modeling appropriate responses will teach non-handicapped children how to respond.

Possible	Adult Responses	Adaptions
4. "He's messy when he eats."	Explain that the child has a difficult time eating, but he's trying very hard to do it like him.	Be as matter of fact as possible. Try to pair the child who asked the question up with the messy eater during an activity where the messy eater does well.
5. "She's too slow, does she have to go with us?"	Again, a matter-of-fact response will answer the child's question followed by an explanation of "some of us move fast, some of us move slow."	When going on walks or field trips, try to pace the activity so the handicapped child can keep up, i.e., riding in a wagon with younger children, a stroller.
6. 'I don't want him over here, he knocks my blocks over."	Encourage child to talk to the "block destroyer." You may need to model what and how to say it.	Station an adult near areas that the "destroyer" has trouble in. The adult's job should be to reinforce positive play skills. Over time, as the child becomes more appropriate, the adult will not have to spend as much time in the area.

QUESTIONS COMMONLY ASKED BY PARENTS AND OTHER ADULTS

Questions	Answer
What are the effects of integration on normally developing preschool children?	Integration seems to have no detrimental effects on the social, cognitive or play behaviors of young normally developing children.
Will typical children imitate negative or or inappropriate behavior of the handicapped children?	Research supports that non-handicapped children do not imitate socially unacceptable or immature behaviors in free play or structured activities.
Will the progress of non-disabled peers be limited?	Studies have found that non-handicapped children made expected progress in settings where handicapped children were integrated.
What type of social interaction can be expected in an integrated classroom?	Non-disabled children may prefer to play with their non-disabled peers rather than their handicapped peers but overt rejection is rare. Simply placing disabled and non-disabled children in the classroom does not insure that these children will play together. Interaction among handicapped and non-handicapped children can be facilitated by teaching strategies and environmental planning.
Will handicapped children have a difficult time communicating with their non-handicapped peers?	Studies have shown that non-disabled children will adjust their verbal interactions in a way that insures that their developmentally delayed peers will understand messages.
Will handicapped children be bullied or mistreated by more aggressive non-handicapped peers?	Typically non-disabled children are gentle with handicapped peers and will try to help, teach, encourage and demonstrate affection to handicapped children.

ACTIVITY E1
TIME ALLOWANCE 10-15 MIN

IT'S ALL IN WHAT YOU SAY

PROCEDURE:

1. After reviewing handout E4, distribute 1 index card to a group of 4 or 5.

2. Have each group describe possible adult responses and additional things the teacher could do in the classroom to make all involved more comfortable.

3. Have each group share what they discussed.

4. Have each member add suggestions from the group discussion to their handout.

MATERIALS:

Index cards with a question written on each one:

- "I'm helping her, she can't do it."

- He's always falling and bumping into things.

- "Why does she come in a bus?"

- You notice some of the children imitating a child who has trouble walking, etc.

ACTIVITY E2
TIME ALLOWANCE 10 MIN.

Q-SORT

PROCEDURE:

1. Place the form board in front of you. There are twenty-five squares in which to place playing cards. Each vertical row is labeled at the bottom. The labels going from left to right are: "applies only to early childhood education" through "applies only to special education". There are varying degrees of application in the middle squares. The vertical rows are numbered for a visual aid.

2. Look at each playing card. Many of the items printed on the cards will be more characteristic of early childhood education or special education. Some of the items could go in either category. Place each playing card in a square in the vertical row according to which category you feel it <u>most</u> characterizes. Although some items will be difficult to categorize, only one playing card can be placed on each square. All the squares will be filled at the end of this exercise.

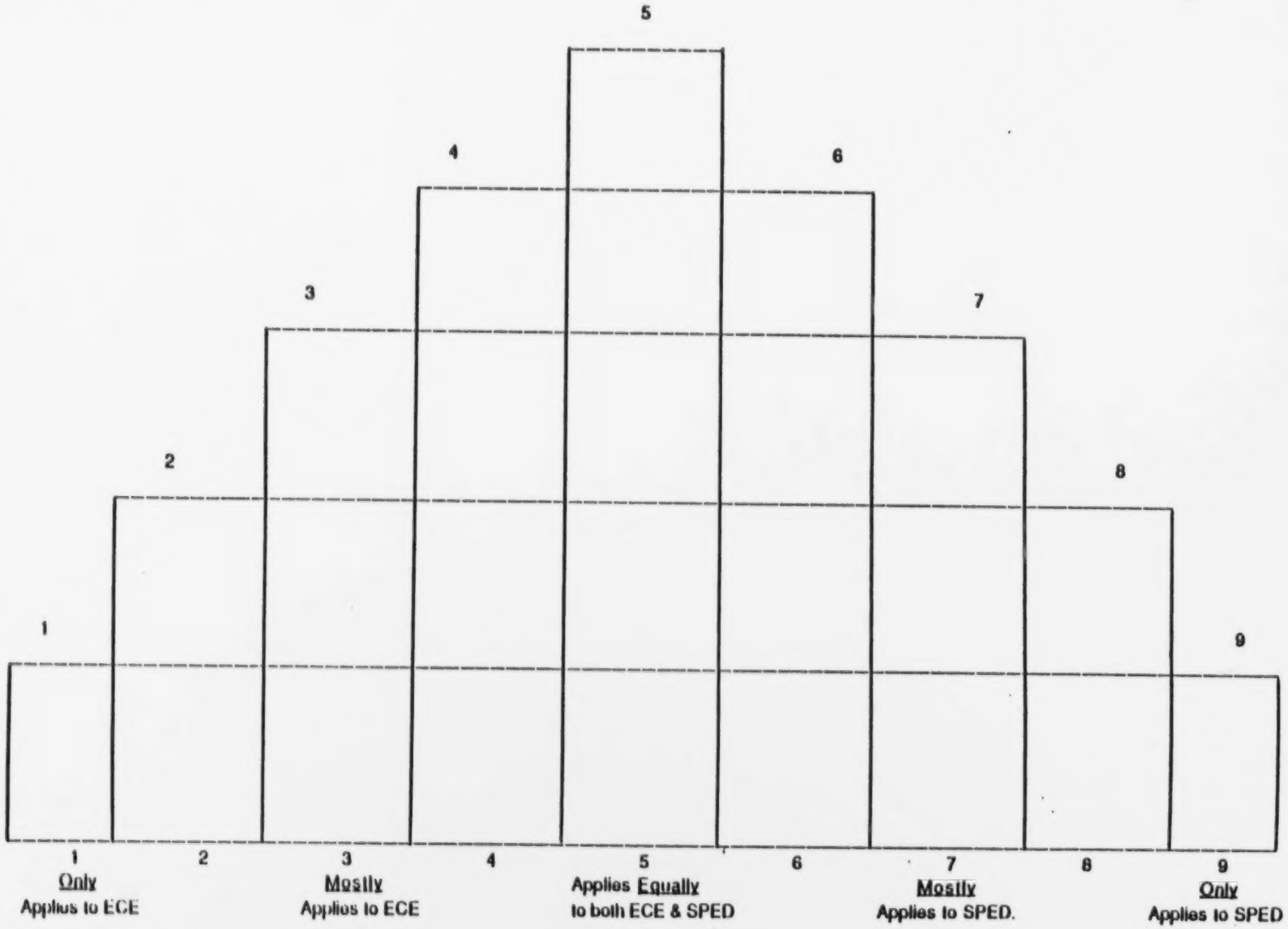
3. If there is only one participant, think about why you chose certain items to categorize in a particular way. Try to clarify your values, attitudes, and philosophy about special education and early childhood education.

   If there is a group, discuss the similarities and differences between early childhood education and special education, as well as the values, attitudes and philosophy that went behind choosing certain items for a particular category.

MATERIALS:

1. Playing cards cut in pieces for each person (See Handout E5).

2. Pyramid for each person (See Handout E6).


5
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Only
Applies to ECE
Mostly
Applies to ECE
Applies Equally
to both ECE & SPED
Mostly
Applies to SPED.
Only
Applies to SPED
Early Childhood Educ. (ECE)
Special Education (SPED)

PLAYING CARDS

1 Individual Instruction	2 Competition	3 Parent Involvement	4 Structured Learning	5 Gross Motor Activities	6 Free Play Opportunities	7 Small Class Size	8 Learning Centers
9 Developmental Approach	10 Self-selection Activities	11 Intensive Therapy	12 Recess	13 Self-Image Activities	14 Behavior Modification Techniques	15 Large group Instruction	16 Peer Modeling
17 High (1:20) Teacher/Child	18 Music	19 Individualized Education	20 Performing in Front of Others	21 Parent Conferences	22 Report Cards	23 Remediation Approach	24 Cooperative Learning
25 Time-Out Procedure							

*Cut up into individual squares.

C1

C2

REFERENCES

Hulin, S., & Mengel, P. (1983). New Friends -- mainstreaming activities to help young children understand and accept individual differences. Chapel Hill: New Friends Project.

Edited by Beans, G., Breshears-Ronton, D. (1985). Making Integration Work: A guide to integrating Handicapped & Nonhandicapped Preschool Children. Grant No. G008402286 Project AIM Outreach.

TEACHING STRATEGIES

TEACHING STRATEGIES

SUGGESTED OUTLINE

OBJECTIVES	OUTLINE OF ACTIVITIES
Participants will:	
1. Know general teaching strategies (i.e., modeling prompting, etc.) and relate them to teaching specific skills.	1.1 Review teaching strategies (See Handout T1). 1.2 After each participant completes Assignment T1, discuss their answers. Write ideas on a chalkboard or large sheets of paper. Relate ideas back to teaching strategy handout. 1.3 Complete activity "Skills across the day" Activity T2 or T5 "What Do I Do?" with participants. (Transferring-generalization) 1.4 Complete activity T3 "Breaking Down Tasks" with participants.

2. Understand the importance of social skills and how to teach them using basic teaching strategies.	2.1 List with participants, social skills children acquire in preschool. Discuss teaching strategies to teach social skills (See Handout T2). 2.2 Complete "Scenario" (Assignment T1) with participants. Discuss. 2.3 Discuss a social skill that one of the participants' students may have. Choose one of the participants to be the recorder. Write student's problem on the board. Brainstorm with group different strategies to teach appropriate skill. Have participants role play one of the solutions. 2.4 Complete Activity T4, "Play is a Child's Work".
3. Have an understanding of how to stimulate language throughout the preschool schedule using the teaching strategies discussed previously.	3.1 Review Handout T3 "Ways to Stimulate Language" with participants. 3.2 List (or have listed) each part of the day on a blackboard or large sheet of paper. Ask participants to list ways that language could be encouraged during each part of the day.

LOOKING AT TEACHING SKILLS

There are constant decisions that are made by staff who work with children. When children with special problems are added, that process becomes more complicated. The process of increasing child learning is still the same - whether a child is "normal" or "handicapped."

First look at what is being taught:

A. Assessment - What will actually be taught? Which children understand the concept and which ones do not.

B. Why? Identify what skills are really important and why it is important that a particular child or children be taught the skill. Are there other skills that would be more important?

C. Developmental level - Examine whether the intent is at the upper level of difference. Can each child be successful at what they're doing or does the skill need to be easier.

D. Methods of instruction - Skills can be taught a variety of ways by using modeling, shaping techniques, prompting, task analysis, practice, fading (See "Teaching Strategies" handout).

Teacher and student behavior are also considerations to examine when making decisions regarding activities that will benefit children.

There are parts of the environment that can be manipulated.

1. <u>Reinforcement</u> - Adults in the room set the general "feel" in the classroom. There should be a ration of 4 positive comments to the class as a whole or individual to every negative comments.

   Some questions to ask are:

   - Is there a positive atmosphere in the room?
   - Do staff members smile with approval at the children?
   - Do the children appear happy?

2. Transferring or Generalization - Children with learning problems may learn a skill with certain materials, but may not be able to do it with in a different situation, with different materials. When opportunities are given to use new skills in different ways, children will be much more competent. Preschool settings are perfect places for this and are usually overflowing with ideas to teach skills in a variety of ways.

   Questions to ask:

   - Are there opportunities during different times of the day to use new skills?

   - Are a variety of materials used to teach a skill?

3. Practice - Practicing new and old skills in fun ways gives children opportunities to retain skills and use them in different ways.

   - Do children have opportunities to practice their new skills using hands-on experiences?

   - Do children have opportunities to use new skills in a "real life" activity.

   - Are activities planned based on what skills children actually need?

TEACHING STRATEGIES

1. Modeling

Definition: Showing a child how to behave or perform a task by having her watch someone else.

Key Phrase: "Watch me"

Example:

Goal - The child will interact positively with pets.
Strategy - Adult or another child shows the child how to pet, feed and approach a pet.

Tips:

1. Use modeling as a first step in teaching a new task.
2. The person who models the behavior should be like the child.
3. The person who models the behavior should be reinforced for doing it.
4. The child who is watching the person should see the model in a positive way.
5. Talk with the child about what she is watching.
6. The behavior that is modeled for the child should <u>not</u> be more difficult than the one the child is to do.
7. Be careful of <u>what</u> is modeled since children are great imitators!

2. Shaping

Definition: Reinforcing small improvements until the skill or behavior has been perfected.

Key Phrase: "You're getting close."

Example:

Goal - The child will draw a circle.
Strategy - When the child can do this , gradually shape the drawing into this .

Tips:

1. Use shaping when the child is learning a new and difficult behavior, or when the child knows how to do the behavior somewhat.
2. Reinforce small improvements since it's better to over-reinforce.
3. Figure out what the child <u>can</u> do right and then add on.
4. Watch the child closely so you can determine the right steps in the shaping process.
5. Stay at each step in the shaping process as long as necessary.
6. Make sure your shaping process is very gradual.

- Shaping allows the child to be successful, even when she/he can't accomplish the final goal right away.

3. Prompting

Definition: Signaling or cueing to help a child perform a behavior that she otherwise would not or could not do. There are three types of prompting: Visual, Physical and Verbal.

Key Phrase: "A little nudge."

A. Visual Prompting - providing something the child can see to complete an activity or perform a behavior.

Example:

Goal - The child will attend to sounds by looking in that direction for increasing lengths of time.

Strategy - Adult points to door, then cups fingers around her ear and says, "Listen, I think I hear the record player!"

Tips:

1. Use visual prompts for both simple and complex tasks.
2. Add something "extra" to what is to be learned in order to make it easier to recognize.
3. Tasks can be visually prompted by changing the color, texture, location, size, etc., of what is to be learned.

B. Physical Prompting - Physically helping the child to perform t the behavior by leading the child through the activity.

Example:

Goal - The child will imitate a sequence of two simple motor behaviors, e.g., clapping hands.

Strategy - Adult places her hands over child's hands and claps them in front of the child's body.

Tips:

1. Prompt only the necessary parts of the behavior (if a child can't steer a tricycle, help her steer, but don't push the tricycle also!).
2. Try to do the physical prompts from behind so that the child is looking at what is to be done, and not at the adult.

C. Verbal Prompting - Giving spoken directions or hints by telling the child what to do.

Example:

Goal - The child names the correct color when asked "What color is this?"

Strategy - The adult says, "This one is gr__!"

Tips:

1. Use as few verbal prompts as necessary (don't under or over prompt!).
2. Make the prompts positive.
3. Use the prompts so that the child can be successful.
4. Use with other methods.
5. Fade gradually.

4. Practice

Definition: The child practices a given task by repeating it. It can be practicing a skill or behavior before performing it in a real life situation.

Key Phrase: "Practice makes perfect."

Example:
Goal - The child will count to ten.
Strategy - The adult provides many sets of objects to be counted and then has the child count aloud in various tasks.

Tips:
1. Practice the task in real life or make believe situations.
2. Make the repetitions as interesting as possible.
3. Try to have the child practice in a number of situations.
4. Use lots of praise.

5. Fading

Definition: Reduce the cues you provide during an activity/task.

Key Phrase: "A little less of you."

Example:
Goal - The child recites a rhyme or song.
Strategy - The adult fades her voice as the child is able to recite rhymes or sings from memory.

Tips:
1. Fade your cues very gradually.
2. Fade your reinforcement gradually (don't ever fade completely).

6. Task Analysis

Definition: Method of breaking down a given task into a sequence of simpler tasks.

Key Phrase: "There must be an easier way."

Example:
Goal - The child will name 8 colors
Strategy - The adult begins by working only on 1 or 2 colors until they are well learned <u>before</u> adding other colors.

Tips:
1. Determine what part of the skill children <u>can</u> and <u>cannot</u> do.
2. Only add next skill when the skill before it can be done well.
3. Reinforce correct answer.

STRATEGIES FOR FACILITATING SOCIAL INTERACTION

One of the tasks of young children is to learn appropriate ways to act. Adults can teach children by modeling appropriate behavior, reinforcing children for things they are doing appropriately, and by working on opportunities during the day to interact with others.

Strategy	Description	Examples

Modeling appropriate behavior	- Adults and other children can be used to show children "how" things are done	- Demonstrating such social tasks as:
		  - Sharing
		  - Taking turns
		  - Asking for something another child has
		- Children and adults can be used as models
		- Let's watch John walk to the door. That's right, John!"

Reinforcement	- When children interact appropriately ((i.e., share a toy, play with another child) adults can reimforce child. Not only will the child more than likely try it again, but the action will also serve as a model.	- "Wow! Jane know how to wait by the door." - "Jeff shared his toys today with Sara."
Teacher mediated interventions	- This technique can be used when a child has trouble interacting at all, or when most interactions are inappropriate. This procedure uses a: 1. Prompt ("Jay,, ask Sara if you can use the toy.") Show him by asking Sara "Can I have the truck?" Help Jay through the motions. Then reinforce evem if he just tried.	
Set up situations to encourage interaction by: - Limiting boundaries - Using interactive materials (dramatic play corner, etc.)	When children are learning to play next to each other, share or play cooperatively, the arrangement of the room, the materials and activities that are used can influence the amount of interaction.	- Provide a dramatic play corner - Seat quiet children next to interactive children - Restrict certain toys to an area - Use tables to build on - Have children play in pairs as partners

Incorporating peer interactions into instructional setting	- Group times can be structured to "teach" children social skills, i.e., sharing, standing in line. - Activities can be planned around teaching social skills.	- Have children act out <u>appropriate</u> ways to ask for a toy. - Take Polaroid pictures of children greeting others, ?-ing, standing in line, etc.

STRATEGIES FOR FACILITATING SOCIAL INTERACTION

Strategy	Objectives	Examples
Limit Number of Materials	- To create a need to request, trade, share with peers.	- Limit kitchen materials in playhouse - Limit fine motor items: glue, crayons, scissors - Limit balls, trikes, etc. in gym or playground - Pass snack foods - Limit instruments in music
Limit Boundaries	- To increase probability of child-child interaction	- Use table top to build on - Tape off area on floor to play inside - Restrict toys to carpeted area - Seat children close together
Use Group Time	- To create opportunities for talking to another child	- Have a 'greeter' at the door who greets children as they enter - During group language, show child a picture of a classmate and direct them to greet that child. Expand by having classmates greet the classmate and ask a question (i.e., 'What do you eat for breakfast?')
Withhold materials (Keep out of reach)	- To create a need to ask for items, encourage	- Place art materials out of reach - Teacher control materials - Student control materials - Place desirable toys in view but out of reach

Strategy	Objectives	Examples
Limit Adult Contact	- To promote child-child interaction rather than child-adult interaction	- Place snack items on table and have children serve themselves - When child approaches adult to talk, listen but direct child to tell a classmate - If child asks adult for help, redirect to a child that could help too - Allow child to lead some activities - Have child pass out materials
Select Specific Materials	- To promote social interaction provide variety of toys that are considered social toys	- Doll corner - Props for socio-dramatic play - Block Corner - Trains, cars - Gross motor for 2 or more - Wagon - Climber
Teacher Mediated Interventions (shaping, modeling cueing and reinforcement)	- To facilitate initiation and responding - To extinguish behavior that may interfere with social interaction - To encourage physical proximity - (Goal is to fade teacher support over time) NOTE: 1) Adult help may interrupt the natural flow between two children. 2) Generalization may be limited, child may not use skill spontaneously in different situations.	- Verbal or physical prompt to encourage child to: show something invite share trade greet defend - Reinforce - "You two are playing together so cooperatively." "____ & ____ are sharing."
Model Behavior	- To demonstrate appropriate interactions for children to see or imitate	- Teacher and aide or teacher and another child demonstrate sharing, taking a turn, asking for a toy, a role in dramatic play.

Strategy	Objectives	Examples
Train Social Overtures	- To train children to demonstrate positive social behaviors	- In daily routines rehearse greetings; please, thank you, requests for help, requests for toys. - In group activities teach specific ways to ask other children to play, to share toys, to take turns, to express affection and help other children.
Team Learning Situations	- To provide children with opportunities to work together in setting up group activities - Task of 2 or more parts in such a way that it requires 2 or more children to complete	- Art projects with multiple steps, assembly - Cooking - Assembly toys - One child cuts shapes - Another pastes (roles can be switched so each child practice skills)
Structured Play	- To provide specific play routines, assign sets of children to participate in selected play activities designed to encourage social interaction (initially may need teacher direction)	- Assign dramatic play roles with appropriate props and setting, e.g., beauty parlor, house cleaning, pretend birthday party, doctor's office - Fine motor manipulative and construction toys, e.g., legos, large blocks, city scapes, farm yard with animals - Gross motor, e.g., climbing toys, riding toys, wagons, balls
Structured Game Playing	- To provide age appropriate board games or lotto games to encourage turn taking, sharing, following social rules - To have children play the game by themselves (may initially require teacher direction)	- Lotto - Hi Ho Cherrio - Go Fish - Potato Head - Pic up sticks - Modified Candy Land

Strategy	Objectives	Examples
Seating	- To control proximity of children to increase opportunities to initiating and responding	- Arrange seating during center time, snack, fine motor activities Music Art
Select children to assume leadership role	- To promote children as capable and having leadership qualities to enhance social image	- Identify children to be Line Leader Snack helper
Incorporating peer interactions into instructional settings	- To provide structure to small group activities where children are working on the same activity to facilitate initiating and responding	- Have child hand the material to the child whose turn is next. - Have one child ask another a question or repeat what the first child said. - Have a peer model the correct response when another child does not make correct response, and re-ask the first child the question.
Program for Generalization	- When a handicapped child is producing a desired social behavior with one condition, provide an opportunity to display the behavior with the same child in another setting, then provide opportunity with a different child	- Provide variety of play settings; classroom, playground, gym, park - Vary group combination seating arrangements, play routines

Strategy	Objectives	Examples
Peer Mediated Instruction	- To train non-handicapped children to play with handicapped to increase opportunities for social interaction (for use with more socially isolated children)	- See Strain's Model
Peer Tutoring	- To provide older non-handicapped students to model appropriate social behaviors	- Read stories to younger children - Help with fine motor manipulation - Art activities - Peer "Buddy" in lunchroom or playground
Script Training	- To provide socio-dramatic role playing activities with structured roles and dialogue. (Structure provides context and vocabulary for handicapped child)	- Provide props review roles and "story line" - Rehearse roles until children know activity

WAYS TO STIMULATE LANGAUGE

The literature indicates that the quality of early verbal input to the child is related to developmental outcomes. Teaching language to children happens every day all day long. Being a good language model is very important.

Self-talk

Self-talk is talking out loud about what you 're doing. It includes describing what you're doing.

- Use words that describe how you feel, see, hear, smell and taste
- Speak clearly and slowly
- For younger children use short simple descriptions
- For older preschool children include the sequence, ask questions about what will happen next, have children relate previous experiences, make comparisons

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Parallel Talk

Describing what the children are doing, why they are doing it. Parallel talk should emphasize those concepts missing from the child's language, e.g.:

"I like what you are building. You are stacking them very high. Oops, they fell down." etc., etc.

Formal Group Language

During circle time use it as a time to build vocabulary and introduce new concepts.

Use puppets or surprise boxes to introduce objects or concepts. As with self talk, describe new objects and expand.

Language Model

Expand what a child may say, e.g.:

Child: "Dog bark."
Adult: "Yes, the dog is barking."

Be responsive

When a child talks to you give the child eye contact and let your face reflect interest in what the child is saying.

ACTIVITY T2
TIME ALLOWANCE 10-15 MIN

SKILLS ACROSS THE DAY

PROCEDURE:

1. Divide group into groups no larger than 4.
2. Identify a skill (i.e., using descriptive words in vocabulary or increasing vocabulary or improving pre-writing skills) for each group to focus on.
3. Give each group a skill written on a 3x5 card.
4. Instruct each group to brainstorm 2-3 ideas that could be used during each section of the day's schedule
   - e.g., improve pre-writing skills of training lines.
   - Free play
     1. Tape line on floor to use as a road with small cars.
     2. Paint easel available with line designs on paper
     3. Chalk board with colored chalk
   - Group time
     1. Practice making different shapes in the air
     2. Draw shape, letter or object on child's back, have them guess

MATERIALS:

Paper
Pencil
Center's schedule
3x5 cards with a skill written on each card (i.e., improving pre-writing skills, greeting friends, using descriptive words in vocabulary following group directions, etc.)

Center times--

1. Table activity -- glue objects (i.e., pieces of styrofoam, macaroni, etc.) on simple lines on colorful paper.
2. Science table -- switch set up -- metal tool will play music when it is tracing on line.
3. Gross motor area -- balance beam and tape line to walk and follow.

BREAKING DOWN TASKS

PROCEDURES:

1. Begin the activity by asking class members to write down some of the cognitive and fine motor components involved in building block structures. Here is an example of how it might proceed:

   Task: Building Block Structures with Cubes

Fine Motor Components:	Cognitive Components:
Grasp	Attention Span
Release	Visual Memory
Smooth, coordinated movements	Seeing patterns
Use of two hands together	Spatial relationships
Hand preference	Visual perception

2. Now break the class into groups and give one set of materials to each group. Using the following format, encourage each group to have a volunteer actually work on the task in a normal fashion.

3. Discuss other components that need to be added to their list.

MATERIALS:

Blocks (at least 15 per group).
2-3x5 cards with:

1st card: Student - complete three structure: 1) an 8 block tower, 2) a train and, 3) a bridge as directed by the teacher.

Throughout the session, display an inability to release the block. You also have difficulty with spatial relations. When blocks must be lined up or balanced on another block, display difficulty. Respond appropriately when the teacher encourages you and makes attempts to complete the task correctly.

2nd card: Teacher - you know the student has trouble working with blocks. Make a model of 1) a tower, 2) train , 3) bridge .

Do not teach child to make any of the structures. Praise any attempts to complete the task and give encouragement if needed.

PROMOTING INTERACTION AND COOPERATIVE PLAY BETWEEN PEERS

1. Choosing materials and activities that promote interaction

   a. Materials that promote interaction
      - doll corner
      - sandbox
      - bowl of play-dough
      - block corner
      - trains, cars
      - gross motor materials that require at least two

      Limit the number of toys available and request that the children play in a small area. This will require the children to share and engage in the same activity and therei encourage social interactions.

   b. Materials that do not promote interaction:
      - beads
      - pegs
      - puzzles
      - clay -- if each child has their own portion and tools

   c. Activities that promote cooperation and sharing:
      - cooking -- with all sharing in the activity
      - painting a mural
      - using blocks to build a predetermined object
      - see-saw or rocking boat
      - games

   d. Provide activities or toys that the children are competent with, that require no adult supervision.

2. How to set up activities

   a. Establish a defined physical area for the activity in order to keep the children together. The area can be defined by a carpet area, masking taped-off area, or chalk on the carpet.
   b. Use few enough materials that children are encouraged to trade and share them.
   c. Adults should remove themselves from the play situation when children begin to play together. However, adults may need to promote interaction initially by encouraging children to play together, and by praising them when they do.

3. How to participate in the classroom

a. Teachers can promote interactions by teaching children specific ways to ask other children to play, to share, to take turns, to express affection and to help other children by:
   - Modeling appropriate interactions for children to see or imitate
   - Promoting or making suggestions to: ask or tell something, to show something, to invite, to share or trade, to comment or to defend or greet.
   - Translating or interpreting for children talking to each other who would otherwise not understand each other.
   - Following through to see that children respond to and answer each other's questions or contacts.
   - Assisting children to control their aggressive behavior:
     redirecting
     reminding child when they are losing control

PLAY IS A CHILD'S WORK

PROCEDURE:

1. Choose a theme from "Let's Pretend" in the Appendix (i.e., Airport) and prepare materials before the class session. If the group needs to be divided, choose a different theme for each small group.

2. Discuss "Teaching Social Skills" to children (review of handout) if it has not been discussed previously. Give printed instructions from the theme activities to small group. Assign roles to each member of the group (teacher child who is interacting inappropriately, child who is not interacting, child who is interacting appropriately).

3. Give group about 5 minutes to role play. Switch roles if necessary.

4. Discuss experience. Other strategies may be discussed as well as problems.

MATERIALS:

Choose and copy instructions from theme activity chosen from "The More We Get Together" in the Appendix (e.g., "Let's Pretend" Airport).

- Seats
- Pictures of clouds, sun
- Food preparation props
- Seat belts (rope, young/old belts)
- Play plane tickets, stamp, stamp pad
- Steering wheel, microphone, earphone for pilot and co-pilot

ACTIVITY T5
TIME ALLOWANCE 30 MIN

WHAT DO I DO?

PROCEDURE:

1. Issue each participant a piece of paper and a pencil.

2. Trainer reads following directions to participants with a straight face. Begin slowly but pick up speed in talking.

   Fold this square piece of paper in two along the diagonal. You now have a triangle - (Pause). Mark a point on the diagonal at one-third of the distance starting from the left angle, and another at the middle of the triangle's left side. Fold the left angle along the line between the two points so that the left angle reaches towards the right side - (Pause). Now draw a point at the middle of the right side, draw another point at one-third of the diagonal starting from the angle of the right, draw a line between those two points, and fold along the line you have just drawn - (Pause). In order to finish the cup, separate the two angles of the paper at the top of the old triangle on each side of the cup. Open the cup.

3. If participants ask for repetition of instructions, trainer should repeat directions in an impatient manner ("Okay, but pay attention this time.")

4. Follow-up discussion should rotate to the participant's personal feelings regarding the activity. Discuss range of reactions the group felt.

5. Break up into groups and have each group list ideas in presenting the activity based on learning strategies.

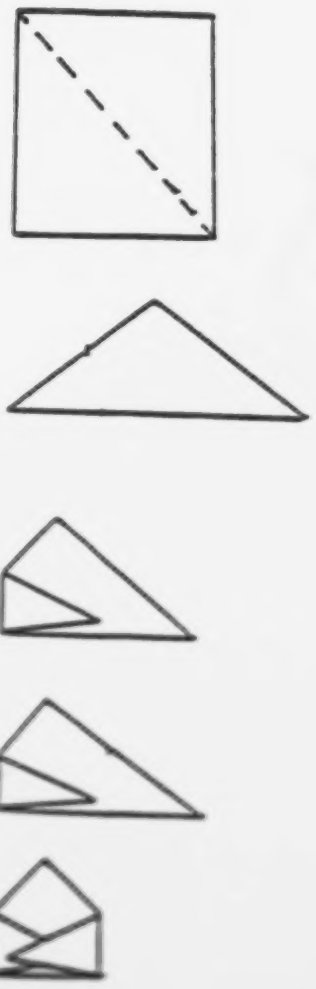
MATERIALS:

For each participant:
Plain 8 1/2" x 11" paper
Pencil

Procedure: (for trainer only)

Diagram: (show group after they have tried)

PAPER FOLDING PROCEDURES



SCENARIO

Read scenario about Fred.

Fred is a 4-year-old child with mild mental retardation who attends a local preschool program. An itinerant teacher has been working with him on drawing sample forms. Fred, during one-to-one instruction, is able to follow the direction, "Fred, look at my ball and draw a ball just like mine." Using a crayon, he can draw a fairly well balanced circular line on construction paper. Usually he makes them randomly on a sheet of paper and does them very slowly with great concentration.

Fred's special education teacher told the preschool teacher that Fred was learning to make circles. During group activity time, Fred's teacher asked the group to draw five circles in a row on the paper. The children were using white paper and pencils to complete the activity. Fred sat and scribbled on his paper while the other children made circles. The preschool teacher was puzzled and annoyed that she had been told Fred could draw circles.

Discuss with participants the reasons Fred did not succeed.

1. Why wasn't Fred able to make a circle as the special education teacher reported?

2. What does Fred's special education teacher need to work on?

3. What teaching strategies could be used to help Fred trasfer the task from the itinerant teacher to the preschool?

Scenario answer key

Possible answers to Fred's scenario:

1. Why wasn't Fred able to make a circle as the special education teacher reported?

   - Fred was in a group instead of a 1-1 situation.
   - A pencil instead of a crayon was used.
   - The directions were different.
   - Fred copied a pattern for his special education teacher. He didn't have a visual cue from his preschool teacher.
   - Fred may not know what 5 is.
   - Fred may not know what row means.

2. What does Fred's special education teacher need to work on?

   - Is she working with Fred individually or in a group?
   - Teacher needs to use different cues -- Fred may be used to one cue.
   - Using different writing tools.

3. What teaching strategies could be used to help Fred transfer the task?

   - Itinerant teacher could work with Fred during the preschool's fine motor time.
   - Fred may need the skill to be broken down into easier skills. When the rest of the children are making 5 circles, have Fred "draw circles."

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BEHAVIOR MANAGEMENT

BEHAVIOR MANAGEMENT

An important issue when working with any child or group of children is behavior management, especially if there is a child who is disrupting the group. Children who are extremely withdrawn may not be disruptive, but still could be cause for concern. This section will emphasize understanding and preventing misbehavior. In addition, strategies for dealing with group or individual problems will be outlined.

First, look through the suggested outline. Ideally a minimum of four two-hour sessions is suggested. The exercises within the section are critical as they give participants practice applying old and new skills. A variety of handouts are included, and may be used at the presenter's discretion.

Follow-up visits are especially important when a behavior problem(s) is a concern. A problem solving procedure to be used in small groups is outlined within the section. This procedure is an important part of the in-service, and should be used to enable regular educators to function as a team and develop behavioral plans that fit their own situation.

DEALING WITH BEHAVIOR PROBLEMS
Suggested Outline

Objectives	Activities
Participant will: 1. Understand concepts in preventing behavior problems, including: a) Effects of the environment and how it can be manipulated to encourage appropriate behavior. b) Examining the developmental levels and determining the needs of children within the classroom. c) The role of the adults and how they can encourage the most appropriate behavior.	1.1 Review Handout B1 "Prevention of Misbehavior" with group. Review and discuss each area. 1.2 Review "Environmental Checklist", Handout B2, with group. The checklist can be used to help staff determine if there are any problems within the environment that can be corrected. **The following sections 1.3 & 1.4 are optional but extremely important.** 1.3 Teach group how to use Early Childhood Environmental Rating Scale (ECERS) (See Appendix B). Fill out one section with participants, request they fill out the remaining scale and bring it with them to the next in-service. The ECERS is a tool that is used to determine areas of strength and weakness in each classroom. 1.4 After the ECERS has been filled out and returned to the following in-service, complete the graph on the last page of the scoring sheet (of the ECERS). Each participant can pinpoint one or two areas they want to work on. That area should be circled on the graph and Assignment B1 "Environmental Worksheet" should be filled out and be kept with the staff member. 1.5 Review Handouts B3-B5 "Emotional Development" and discuss how meeting the developmental needs of children effects children's behavior. Encourage group to add additional areas to each age group, and decide what adults can do to meet those needs.

Objectives	Activities
	1.6 List common behavior problems children at the preschool level display within a group. Write ideas on paper or blackboard. Handout B6, "Common Behavior Problems", lists common behavior problems and ideas to deal with them. Add any additional common behavior problems and have the group determine a variety of suggestions for dealing with them. 1.7 Review and discuss ways we communicate with children by reviewing "Setting Limits, " Handout B7. 1.8.c Complete Activity B1 "Watch Your Words" as a group or Assignment B2 "Let Your Words Work for You" individually.
2. Understand importance of teaching appropriate ways to interact (or teaching appropriate social skills).	2.1 Review Handout B13 and discuss asking for other examples **OR** Do Activity B2
3. Be able to demonstrate ability to set up a group or individual behavior program with participants.	3.1 Outline basic concepts of behavior management with participants using handouts regarding reinforcers, sending positive directions, weakening and decreasing behaviors and timeout rules. (Handouts B10-B14) Amount of time spent depends on groups understanding of behavioral concepts. 3.2 View video tape, "I Worry About Behavior Management" from The Young and Special Series (See appendix for instructions on how the video tapes can be ordered). Follow-up with a discussion. Video emphasizes catching child being good. 3.3 Complete Assignment B3 (Three Scenarios) with participants. Discuss. 3.4 Review Handout B8, "Managing Behavior" with participants. 3.5 After completing 3.4 each participant needs to identify a child in their classroom or center who is problematic. Request each member of the group take a few minutes and complete Assignment B4 "Behavior Problem-Solving Worksheet". Each item can be discussed in a small group. The program should be in a useable form that can be implemented in their classroom at the end of the session. The baseline

Objectives	Activities
	information will need to be completed before the next session. Request they bring it with them when you return and spend a few minutes at beginning of each successive meeting discussing progress and revising programs as needed.
	3.6 The "Problem-Solving Worksheet (See Handout B15) is an effective tool to use with a small group when developing strategies for working with problem children. The worksheet is an excellent consultant-type tool to use on follow-up visits, but can also be used to teach the group to work as a team.

PREVENTION OF MISBEHAVIOR

Look at your environment.

The environment is important to all people. Much thought and expense is put into buildings such as restaurants, doctors' offices, malls and schools. Not only is the building or office supposed to be physically comfortable, but visually comfortable and interesting as well.

Children, as well as adults, are influenced by their environment. Keeping that in mind, consider how the environment effects children in regard to each of these areas:

1. Look at the space.

a. Planning a well organized space
   1. Children learn to organize themselves, and in turn, their thinking skills when their environment is organized.
   2. An organized environment helps eliminate unnecessary confusion and stimulation.
   3. How can the environment reflect organization?

b. Well defined traffic patterns
   1. Children should be able to move freely from area to area with out disrupting other children.
   2. Equipment should be placed in such a way as to encourage appropriate movement with in the room.
   3. Name some ways the room can be arranged to enhance good traffic patterns.

c. Predictable daily routine
   1. Routines at an early age give children a feeling of security and help them organize themselves.
   2. Spontaneity within the routine is healthy.
   3. Routines help children learn self-control.

d. Smooth transitions
   1. Long waiting periods encourage misbehavior.
   2. Transitions that help children focus on the task, and gain control of themselves, will encourage self-control.
   3. What are some strategies you use for transitions?

2. Look at yourself

a. Observe your reactions

1. Do you catch children being good more than catching them when they mess up?
2. Do you pay attention to children mostly when they're misbehaving or behaving?

b. Let your language work for you

1. Setting a positive climate within your room will encourage positive behavior.
2. Verbally reinforce the group for appropriate behavior.

c. Create a pleasant/accepting atmosphere

1. How often do the adults in your environment smile at the children?
2. Greet children when they arrive and let parents know something positive their child did that day.

d. Supervise children's activities at all times

1. Preventing problems can begin by supervising children in a positive way.
2. Assigning staff members near problem children to catch them being good can enhance all children's behavior.

3. Know your children

a. Observe behaviors and consequences given to the group and individual children

1. Focus on rewarding appropriate behavior by giving children attention.
2. Avoid keying in on misbehavior. Sometimes misbehavior can get more attention than appropriate behavior.

b. Know what is typical for children of your group's age

1. Knowing what behaviors are common, and helping children through problems by teaching them another way, can prevent future problems.
2. What are common characteristics for the children's age group you work with?

c. Enhance relationship between parent and child

1. Remember to compliment the child in front of the parent when appropriate. Sometimes care givers/teacher only report mistakes children make.
2. When teacher elevates parent/child relationship it pays off with all-around improved behavior.

ENVIRONMENTAL CHECKLIST

PHYSICAL SPACE

Equipment

Are there enough tables and chairs for all the students?	Yes	No
Are the tables and chairs the right size?	Yes	No

Seating Arrangements/Locations

How is seating arranged during times when students' attention is is directed to adult (circle time, music, story time, etc.)		
Can students sit by each other without disturbing one another?	Yes	No
Are there any children who have trouble sitting?	Yes	No
During teacher directed activities, is the activity placed near or in view of a distractible area (bathroom, entrance, noisy kitchen)?	Yes	No
What is the noise level in and out of the room?		

TIME

Is there a predictable routine that the children understand?	Yes	No
Do the adults refer to the routine (e.g., "First we will have free time, then we will have snack.").	Yes	No
Do the adults prepare children for changes (e.g., "We need to leave in 5 minutes. Please finish your game." "You can slide 3 more times and then it will be time for a story")?	Yes	No
What is the time frame of each activity (5, 10, 30 minutes)?		
Do the students remain engaged in the activity during the planned time?	Yes	No
Is the amount of time spent at each activity too long or too short?		
Give consideration to when a certain activity occurs:		
What activity comes before nap time?		
Is it an active one or a calming one?		
Do the children have trouble settling themselves down after a busy activity?		

Are the children in one position for a long period of time (i.e., sitting at a table)?	Yes	No
Is the activity schedule evenly planned for a variety of experiences (e.g., using all senses and large motor as well as small motor)?	Yes	No

COMMUNICATING

Do adults communicate specifically and clearly what their expectations are?	Yes	No
Do adults get the children's attention before giving directions?	Yes	No
Are directions stated in a positive manner?	Yes	No
Are choices offered when the teacher does not intend on giving a choice?	Yes	No

TO GROW UP HAPPY, EVERY CHILD NEEDS:

TO FEEL LOVED

- To be held and played with
- To know that adults love, want and enjoy him
- To know that what happens to him matters to someone

TO FEEL ACCEPTED

- That adults like her for herself, just the way she is
- That they like her all the time, and not only when she acts the way they want her to act
- That they always accept her, even though they may not approve of the things she does
- That they will let her grow and develop in her own way

TO HAVE A MODEL

- To have grown-ups around him who show him by their own example how to get along with others
- To have friendly help in learning how to behave towards persons and things

TO HAVE A FEELING OF ACCOMPLISHMENT

- That the adults in her environment want her to grow up and that they encourage her to try new things
- That they have confidence in her and in her ability to do things for herself and by herself

SOMETHING TO BELIEVE IN

- A set of moral standards to live by
- A belief in the human values - kindness, courage, honesty, generosity and justice

TO FEEL SAFE

- That his school is a good, safe place he can feel sure about
- That the adults in his environment will always be on hand, especially in times of crisis when he needs them most
- That he belongs to a family or group; that there is a place where he fits in
- That they will help him when he must face strange, unknown and scary things

TO LEARN THAT SHE IS RESPONSIBLE FOR WHAT SHE DOES

- That blaming others or the situation does not excuse her for what happens
- That if she unknowingly hurts someone, it is her duty to try to correct it

TO LEARN SELF-DISCIPLINE

- That there are limits to what he is allowed to do and that the adults will hold him to these limits
- That though it is all right to feel jealous or angry, he will not be allowed to hurt himself or others when he has these feelings

Adapted from: Family Day Care Providers, 1986, Frank Porter Graham, Chapel Hill, NC.

EMOTIONAL DEVELOPMENT
Toddler

AS THE 2 YEAR OLD GROWS, HE WILL...	SO THE 2 YEAR OLD NEEDS...	YOU CAN HELP BY...
Need to feel safe and secure	- A safe/calm environment - Feeling of security - Places to go that are quiet, small and private	- Reassuring the 2 year old - Talking gentle - Giving attention by talking, giving eye contact, smiling, and giving gentle hugs and gentle squeezing
Be adult oriented	- Opportunities to be with adults and not just play with other children	- Rotating from child to child giving pats, smiles, and conversations, when they are playing well
Be demanding and want things their way	- Adult supervision - Direction to act as a good model and direct them how to ask for things - Reassurance when they can't have their way	- Supervise play and work areas - supplying language stimulation reassurance - Reassuring child when they can't have their way
Have some aggression attacks (i.e., biting, hitting, destroying objects)	- Opportunities to play alone - Adequate number of materials in each area - Nurturing adults	- Telling them what to do instead of just saying "No" - Supervising play areas
Need basic needs met fed toileting sleep	- Structured environment - Predictable routine - with reminders what will be next - Schedule that includes regular bathroom trips	- Generally sticking to a familiar schedule - Providing routines (i.e., toileting, feeding routines that include hand washing, tooth brushing)
Need pleasurable experiences	- Pleasurable experiences that are planned	- Providing sensory activities - Providing activities that will bring pleasure - Activities kept short - Providing variety of activities - Snack time should be pleasurable

EMOTIONAL DEVELOPMENT

3 Year Old

AS THE 3 YEAR OLD GROWS, HE WILL...	SO THE 3 YEAR OLD NEEDS...	YOU CAN HELP BY...
Need to feel safe and secure	- A safe/calm environment - Feeling of security - Places to go that are quiet, soft and small - To feel accepted and important - To know their needs will be met	- Giving attention to each child as much as possible - Smiling and gently touching the children - Providing an environment that is predictable, well-ordered and positive - Meeting child's needs in a regular and reasonable manner
Be somewhat adult oriented but will begin playing next	- To be guided and show appropriate ways of interacting with other children	- Providing enough materials so children don't have to fight over toys or materials - Providing themselves as a model for interaction - Reinforcing positive interaction - Planning for adults in the room to be in proximity and encourage interaction
Begin to master some materials and tasks	- Successful experiences with a variety of materials - To be encouraged to complete tasks	- Avoiding projects that have to be complete a "certain way" - Providing stimulating materials and providing daily opportunities to participate - Encouraging a
Say "No" several times a day	- Choices - Opportunities to be heard and understood	- Giving choices, i.e., "Would you like to play with the blocks or play in the house corner." - Avoiding reacting every time the child says "No." If every "No" is turned into a crisis we may make things worse than they actually are. - Giving directions that are firm but allow the child some variance in responses

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EMOTIONAL DEVELOPMENT

4 Year Old

AS THE 4 YEAR OLD GROWS, HE WILL...	SO THE 4 YEAR OLD NEEDS...	YOU CAN HELP BY...
Need to feel safe and secure	- A safe/calm environment - Feeling of security - Places to go that are quiet, soft and small - To feel accepted and important - To know their needs will be met	- Giving attention to each child as much as possible - Smiling and gently touching the children - Providing an environment that is predictable, well-ordered and positive - Meeting child's needs in a regular and reasonable manner
Need independence	- Opportunities to do things on their own - To feel important and competent	- Providing activities 4-year-olds can complete by themselves - Displaying childrens' work - Talking to parents about positive things their child has done that day - Allowing time for children to complete self-help skills
What are some other needs of 4 year olds?		

STAGES OBSERVED IN THE DEVELOPMENT OF A TODDLER FRIENDSHIP

Stage Number	Stage Name	Salient Characteristics
1	Attraction	Something about the appearance of one child interests another and causes him or her to approach the child.
2	Exploration	Neutral: Close-up, intense gazing and touching or patting of (usually) face or hair. Aggressive: Grabbing roughly, hitting or pulling hair. Passive: A child deliberately places him/herself in a position to be touched or grabbed.
3	Cooperative, Referred Play	Interactive play between peers; literal play without symbolism that involves the active participation of an adult as facilitator and mediator.
4	Unbuffered, Reciprocal Imitative Play	Partners imitate each other's actions or vocalizations with exaggeration, seemingly seeking imitation; adult not involved or involved only peripherally as sometime interpreter of one child's behavior for the edification of the other child.
5	Sharing Objects	A shared toy or object acts as the catalyst and focus of the play (shared activity). Adult's role is as in #4.
6	Discovering and Sharing Humor	One child perceives something as funny, or does something he thinks is funny and laughs, and the other child shares his perception and laughs with him or her. The laughter is intense and protracted.
7	Early Cooperative, Representational Play	The adult's role is as in #4 and #5 but the children show the beginnings of pretend or symbolic play, e.g., pretending to be angry, sleepy, etc.
8	Enlarging the Friendship Circle	A third child is attracted to the "happy pair" makes friendly overtures to them, and succeeds in gaining admittance to their circle.

- From unpublished paper by Billie Press, Ed.D. and Stanley Greenspan, M.D.

COMMON BEHAVIOR PROBLEMS

Behavior Problem	Suggestions for Dealing With the Problem
TEMPER TANTRUMS	
For younger children, temper tantrums are usually a sign of frustration and anger--usually because the child does not have the chance or the ability to be independent and make his own decisions. Temper tantrums can also occur when basic needs have not been met (i.e.,hunger, thirst, sleep).	For younger children (under 3) the anger may come from not being able to control things around them. The child needs to be reassured you understand, and that their needs or wants will be met. Give a soothing pat and a comment, i.e., "You can play with the truck when Jim is finished." then redirect the child to another toy. Make sure when the other child finishes with the toy, you give the toy to the child and say, "Jim is finished with the truck, would you like to play with it now?" Redirect child when you notice child is becoming frustrated. Avoid fussing or calling attention to the child who is tantruming. Treat the tantrum matter-of-factly, briefly give reassurance, and continue with what you are doing.
Older children (over 3) are probably trying to use the tantrum to get what they want. They need to learn more appropriate ways to tell others they want something.	When another child tantrums, they may be doing it as a form of control. IGNORE this kind of tantrum. Don't give the child what he wants, or show that the tantrum bothers you. Tell the child in a matter-of-factly voice, "When you're finished, we'll talk about it." Teach children appropriate ways to express anger. (Refer to section on teaching social skills and teaching strateies.)

SHARING

Children under 3 should not be expected to share. It will also be difficult for a child 3 or older to share.

Children have the right to their own things, but a child needs to feel secure enough to be able to let go of things.

Make available several toys that children have trouble sharing so children can play next to each other without having to battle for preferred toys (this is important for children under 5).

Designate some toys as the "share toys" that 2 or more children must play with together. Adult should initially play with small group to model sharing and to reinforce other children when they share.

Point out children who are showing appropriate sharing skills, i.e., "Look! John is sharing the cows with Janet and Steve."

ANGER

Some anger is normal and is a part of each child's growth and development. People show anger when they are tired, embarassed, hurt, afraid, jealous or frustrated.

You as the adult, has the responsibility to teach the child to show anger in an acceptable way. This can be done by, for example, prompting the child to talk, i.e., "Tell Joe you want your toy back.", or firmly showing a child that he has gone too far if the child hurts someone.

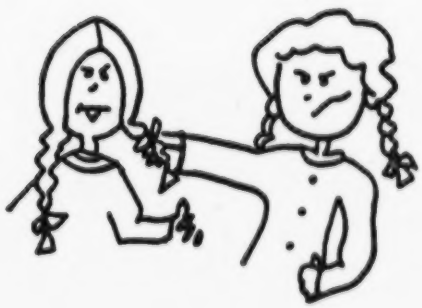
Avoid getting angry yourself. It is O.K. to speak in a firm voice, but not to yell.

ROWDINESS

Learning self-control is a life-long process. Children often have problems stopping an activity and beginning a new one. They also have trouble "calming down" after ending an activity and beginning a new one. They may also have trouble after an exciting or active activity.

Children need to learn how to calm themselves down after a stimulating activity. Using transition activities and refocusing children's attention is an appro-. priate strategy.

Give warnings before stopping activities, i.e., "In 5 minutes we will be putting our toys away."



Approach children who usually have trouble stopping, and gently tell them to start cleaning up because you need their help to get ready for the next activity.

Review rules with children before a known rowdy activity, and what the consequence will be if anyone breaks the rules.

Use a gentle voice, along with a calming touch on the shoulder or back to help calm children if they are out of control.

Removing a child who is out of control from the room for a few minutes, (2 or 3 minutes) may give the child a chance to regain control of themselves.

SETTING LIMITS

Setting effective limits is an essential skill in establishing discipline in a classroom setting. Examine and practice each until it is incorporated into your discipline style.

	EXAMPLES
1. **BE SPECIFIC AND CLEAR** Rather than giving vague and generalized directions, communicating specifically and clearly what your expectations are. The language which is used should describe briefly the limit in observable terms. This makes it possible for both teacher and child to know what is expected.	**Vague and General** - "During circle time be nice or take time out. "You can behave better than that." - "Straighten up and act like you're supposed to in free play. **Clear and Specific** - "During circle time keep your hands and feet to yourself. - "At the table, use your spoon to eat and keep your chair legs on the floor." - "Use your inside voice and your walking feet during free play."
2. **BE SIMPLE, BRIEF AND TO THE POINT** When you are setting a limit, make sure the limit is stated as briefly and simply as possible. When explanations are too long, young children often cannot understand what is being said and stop listening. It is easier for children to remember limits that are stated with fewer words.	**Long-Winded and Complex** - "I can't let you hit Bobby, even if you are angry. Hitting is impolite and someone might get hurt. You wouldn't want to hurt anyone, I know, and you don't like it when people hurt you." - "It's impolite to interrupt. It hurts peoples' feelings when you interrupt and it's hard to hear. We've talked about our interrupting rule lots of times. **Simple and Brief** - "Hitting is not allowed. When you're angry, you can tell Bobby, 'It makes me mad when you take my toy.'" - "One person takes a turn during circle time."
3. **STATE DIRECTIONS POSITIVELY** Directions given in a positive way encourage positive behavior, set a friendlier tone, increase a child's desire to cooperate and give him/her guidelines for meeting your expectations. Children are likely to follow suggestions you give them, so if you say, "Stop running in the room," you may be giving them the idea of running around the room. Stating "We walk inside the room," gives the child a more positive suggestion of what they are to do instead of running. If you do use a statement of beginning "Don't", add the positive statement at the end of the sentence.	**Negative** - "Don't leave crayons on the table." - "Don't spill your food all over the table." - "Don't paint on the wall." - "Don't scream inside." - "Stop running." **Positive** - "All crayons belong in the container as soon as you're finished with them." - "Keep your food on your plate." - "Paint belongs on the paper. - "Use your quiet voice inside." - "Walk inside, run outside."

4. **OFFER ALTERNATIVES FOR UNACCEPTABLE BEHAVIOR**

Often when children are engaging in inappropriate behaviors and have to stop, they are unable to figure out what to do instead. Children need help finding acceptable outlets for the feelings which are causing them to act inappropriately. When you have to stop a child's behavior, try to build in a suggestion for an acceptable alternative into your limit.

No Alternative

- "I can't let you throw the puzzle pieces.
- "Throwing sand is not allowed."
- "Stop tearing the book."

Alternative Provided

- "I can't let you throw the puzzle pieces. If you are angry, you can use words to tell me about it.
- "Throwing sand is not allowed. If you need to throw, you can throw the ball."
- "Books are for reading. You can tear the old newspapers in the art center."

5. **ELIMINATE QUESTIONS YOU REALLY DON'T MEAN TO ASK**

Only ask questions when you expect an answer or can accept whatever choice the child makes. Use a clear statement rather than a question when you are giving a direction.

Unclear Questions

- "Will you put your coat on?"
- "Will you come to group time?"
- "Do you want to help me clean?"
- "Do you know where your contract is?"

Clear Statements and Requests

- "It's time to put your coat on before we go outside."
- "You need to find your space in the circle."
- "It's clean up time. It's time to put the blocks away."
- "Contracts are kept in the box by my desk. Please get yours."

6. **CHANGE AUTHORITARIAN WORDS TO REQUESTS**

Using words like "you have to," "you must," "do it now" can often produce negative responses. When expectations are presented in an objective and factual way, children are more likely to cooperate with your request.

Authoritarian

- "You have to put the bike up now."
- "You should stop bouncing that ball inside."
- "Stop messing with those coats!"

Firm and Specific

- "The bike belongs in the shed."
- "Balls are for bouncing outside."
- "Coats belong on the coat rack."

7. **OFFER CHOICES**

Offering children choices allows them to make decisions and take responsibility for their own behavior. Choices not only help children develop their own preferences and individuality, they can be useful in limit setting. You can have children choose between two alternative permissible behaviors. Choices can also be used to help children get started on activities they are not motivated to do. Before offereing a choice remember to make

Command

- "You must work at the game center."
- "Stop hitting."
- "Get that gum out of your mouth."
- "Clean up all that finger paint, now."

Choice

- "Would you like to work at the game center on a puzzle or with the pegboard?"
- "You need to sit with your hands to yourself during circle time or leave the group."

sure that the options are acceptable to you, and be prepared to go along with whatever they choose.

- "You can put the gum in some paper and give it to me or throw it in the trash."
- "It's time to clean up the finger paint. Do you want to wash the table or your arms first?"

8. <u>USE EXTERNAL REFERENCES FOR SETTING LIMITS</u>

Using external references (i.e. a clock, bus, an activity) can help children accept a limit without resisting. It's much more difficult for children to have a power struggle with an object or a concept that with a person.

<u>Personally Stated</u>

- "You must stay on your cot until naptime is over."
- "I will tell you when it's snack time."
- "I want you to clean up now."

<u>External Reference</u>

- "When the big hand is on the 3, naptime is over."
- "When the lights blink, it will be time for snack."
- "After all the centers are cleaned, we will be able to go outside."

Adapted from: "Setting Limits," <u>Tips for Teachers of Young Children Project Enlightenment</u>, Wala County Public School System, 1984

MANAGING BEHAVIOR

Behavior is taught by someone. There are two people involved -- a learner and a teacher. The things we do have been taught -- either by us observing someone, or actually being taught by someone.

What to do:	
Identify the problem	Describe the problem Use words that are description rather than vague.
Observe the behavior	Observe the behavior a. Answer these questions When is it happening? Where is it taking place? Why do you think he/she is doing it? b. Consciously observe and keep data for a 3-5 day period. Keep data simple as possible. Keep the information during a short period of time (10-30 min) rather than all day. Some behaviors need to be observed whenever it occurs, but behaviors that happen frequently can be observed for shorter times.
Identify positive behavior	Determine what positive behavior is to replace the inappropriate behavior Select a teaching strategy (See: "Teaching Strategies" handout in the Teaching Strategy section) to teach appropriate behavior
Identify reinforcers that would be effective	Explore social, activity or token reinforcers (See "Reinforcer" handout for specific ideas).

STRATEGIES FOR FACILITATING SOCIAL INTERACTION

One of the tasks of young children is to learn appropriate ways to act. Adults can teach children by modeling appropriate behavior, reinforcing children for things they are doing appropriately, and by working on opportunities during the day to interact with others.

Strategy	Description	Examples

Modeling appropriate behavior	- Adults and other children can be used to show children "how" things are done	- Demonstrating such social tasks as:
		  - Sharing
		  - Taking turns
		  - Asking for something another child has
		- Children and adults can be used as models
		- Let's watch John walk to the door. That's right, John!"

Reinforcement	- When children interact appropriately (i.e., share a toy, play with another child) adults can reinforce child. Not only will the child more than likely try it again, but the action will also serve as a model.	- "Wow! Jane know how to wait by the door." - "Jeff shared his toys today with Sara."
Teacher mediated interventions	- This technique can be used when a child has trouble interacting at all, or when most interactions are inappropriate. This procedure uses a: 1. Prompt ("Jay, ask Sara if you can use the toy.") Show him by asking Sara "Can I have the truck?" Help Jay through the motions. Then reinforce even if he just tried.	
Set up situations to encourage interaction by: - Limiting boundaries - Using interactive materials (dramatic play corner, etc.)	When children are learning to play next to each other, share or play cooperatively, the arrangement of the room, the materials and activities that are used can influence the amount of interaction.	- Provide a dramatic play corner - Seat quiet children next to interactive children - Restrict certain toys to an area - Use tables to build on - Have children play in pairs as partners

Incorporating peer interactions into instructional setting	- Group times can be structured to "teach" children social skills, i.e., sharing, standing in line. - Activities can be planned around teaching social skills.	- Have children act out appropriate ways to ask for a toy. - Take Polaroid pictures of children greeting others, 7-ing, standing in line, etc.

SENDING POSITIVE DIRECTIONS

TRY THIS	*INSTEAD OF THIS*
HOW FAST CAN YOU PUT YOUR SHOES ON?	PUT YOUR SHOES ON NOW!
NOW YOU CAN REST AND YOU'LL FEEL SO GOOD WHEN YOU WAKE UP TO PLAY	LAY DOWN!
I'LL TRADE YOU THIS TOY FOR THAT THING	GIVE ME THAT!
HOW MANY BEANS CAN YOU EAT?	EAT YOUR FOOD!
BE GENTLE, PET THE DOG LIKE THIS	DON'T HIT THE DOG!
REMEMBER THAT RUNNING IS FOR OUTSIDE	DON'T RUN IN HERE!
IN ONE MINUTE YOU CAN HAVE A TURN, NOW IT'S HER TURN	STOP GRABBING!
IT SURE WILL HELP ME OUT IF YOU FINISH THAT JOB TODAY	GO FINISH THAT JOB!
LET'S SEE IF WE CAN FIGURE OUT A BETTER WAY TO DO THAT	THAT'S NOT THE WAY TO DO THAT!

REINFORCERS

Social	Social Reinforcers * Smiles * Praise -- Be specific, e.g., "You finished the puzzle by yourself, that's really neat!" * Pats * Nods * Recognition to the group, "Look how John is sitting on his carpet square. He remembered our rules!"
Activity	Activity reinforcers are any activity a child likes to do. Any time an activity reinforcer is used it should be paired with praise ("You really worked hard today, let's play outside longer today.") * Getting an extra drink from the drinking fountain * Extra outside time * Riding toys * Time with foster grandparent Examples: "You all remembered our rules so well today, we have extra time to play a game." "John, Paul & Jason lined up right away, why don't you get a drink from the drinking fountain while we're waiting for the others." "This group can go outside first, they cleaned up so well."

Tokens	Token reinforcement is any reinforcement that can be seen, collected and usually exchanged for another reinforcer. Using a token system with preschool children is very tricky. The child should be at least 4-years-old and be able to understand the concept of, "After you get 3 checkmarks, (something else will happen)". Token systems appropriate for some preschoolers: * Giving marks or smiley faces on a chart to to children when they have obeyed a rule. * Poker chips (or anything similar) * "Feeding" a stuffed animal tokens
Physical Reinforcers	* Stickers * Juice * Drink of Water * Cereal * Trinket * "Good" notes to parents

WEAKENING/DECREASING BEHAVIORS

Behavior that is displeasing or inapporopriate can be weakened or decreased by using behavior modification techniques. Below are some guidelines for decreasing behaviors:

- Have a plan. A plan will not only help the teacher, but the assistants as well, carry out behavior plans.

- Use consequences that are logical and immediate -- preschool children are generally too young to understand, "You won't be able to go outside tomorrow."

- Only use stronger methods (i.e., time out, sad corner) when reinforcement and teaching appropriate behaviors has not worked.

- Preschool children need to be taught how to act, control themselves and get along with others. Ways to do that are: modeling; reinforcing positive behavior; demonstrating how children should interact, then prompting and reinforcing child for trys; and intervening when children are having trouble getting along and prompting them how to make their wants known in an appropriate manner.

TIME OUT RULES

> Make sure the time out area is not reinforcing or stimulating.

> When sending a child to time out, the adult should tell the child firmly, but matter-of-factly, that they broke a rule and will have to go to time out (e.g., "No, Sam, we don't kick. Time to go to the time out chair.").

> The child should not be left in time out more than 2-3 minutes after they have quieted down. Use a timer. It will help the child understand how long they will be in the time out area and it will prevent adults from "forgetting."

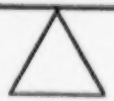
> Avoid frequent use of time out. Investigate other strategies.

> Time out will not be successful unless the child is being reinforced frequently enough when they are displaying appropriate behavior.

IMPROVING CHILDREN'S BEHAVIOR

EXTINGUISHING INAPPROPRIATE BEHAVIOR

TEACHING REPLACEMENT BEHAVIORS



COLLECTING DATA FORM

Behavior observed _____ **Name of Student** _____

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

PROBLEM-SOLVING WORKSHEET

Teacher_____

Visiting Teacher_____

Date_____

Problem

Strengths: _____

_____

_____

_____

Possible Solutions:

	Ratings		
	Good	Fair	Poor
1. _____	___	___	___
2. _____	___	___	___
3. _____	___	___	___
4. _____	___	___	___
5. _____	___	___	___
6. _____	___	___	___
7. _____	___	___	___
8. _____	___	___	___

Solution to be tried first:

_____

_____

Classroom adaptions that may need to be made:

Plan of Implementation

Implementation steps:	Who	When
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Expected outcomes:

_____
_____
_____

How will the plan be monitored?

_____
_____
_____

How will progress be evaluated?

_____
_____
_____

Date and time of next appointment:

_____

Adapted from: Collaborative Teacher Training Project, University of Kansas

WATCH YOUR WORDS

The language we use can effect what children do. Read each teacher direction in the left-hand column. Rewrite the cue so the direction is more appropriate in the right-hand column.

Weak Cues	Stronger Cues
Vague and General Comments "In circle time be nice or take time out." "You can behave better than that" "Straighten up and act like you're suppose to during free play."	**Clear and Specific Comments**
Long-Winded and Complex "I can't let you hit Bobby, even if you are angry. Hitting is impolite and someone might get hurt. You wouldn't want to hurt anyone, I know. And, you don't like it when people hurt you." "It's impolite to interrupt. It hurts peoples' feelings when you interrupt and it's hard to hear. We've talked about our interrupting rule lots of times."	**Simple and Brief**
Stating Directions Positively **Negative** "Don't leave crayons on the table." "Don't paint on the walls." "Stop running."	**Positive**
Offer alternatives for inapporpriate behavior. **No Alternate** "I can't let you throw puzzle pieces." "We do not throw sand." "Stop breaking the crayons."	**Alternate provided**

Avoid threats **Threats** "If you don't do what I told you, you're going to be in trouble." "If you throw that sand, you'll be sorry."	**Clear expectations**
Eliminate questions you really don't mean to ask. **Unclear questions** "Will you put coats on?" "Will you come to group time?" "Will you be quiet please?"	**Clear statements**
Offer choices **Command** "You must work at the game center." "Get that gum out of your mouth."	**Choice**
Refer to external references **Personal statement** "You must lay on your cot until nap time is over." "I want you to clean up now."	**External reference**

WATCH YOUR WORDS

The language we use can effect what children do. Read each teacher direction in the left-hand column. Rewrite the cue so the direction is more appropriate in the right-hand column.

Weak Cues	Stronger Cues
Vague and General Comments	**Clear and Specific Comments**
"In circle time be nice or take time out."	"In circle time keep your hands and feet to yourself."
"You can behave better than that"	"At the table, use your spoon to eat and keep your chair legs on the floor."
"Straighten up and act like you're suppose to in free play."	"Use your inside voice and your walking feet during free play."
Long-Winded and Complex	**Simple and Brief**
"I can't let you hit Bobby even if you are angry. Hitting is impolite and someone might get hurt. You wouldn't want to hurt anyone, I know. And, you don't like it when people hurt you."	"Hitting is not allowed. When you're angry, you can tell Bobby, 'It makes me mad when you take my toy.'"
"It's impolite to interrupt. It hurts peoples' feelings when you interrupt and it's hard to hear. We've talked about our interrupting rule lots of times."	"One person talks at a time during circle time."
Stating Directions Positively	
Negative	**Positive**
"Don't leave crayons on the table."	"The crayons belong in the container when you are finished.
"Don't paint on the walls."	"Paint belongs on the paper."
"Stop running."	"Walk inside, run outside."
Offer alternatives for in-apporpriate behavior.	
No Alternate	**Alternate provided**
"I can't let you throw puzzle pieces."	"I can't let you throw puzzle pieces. If you're angry, tell me with words."
"We do not throw sand."	"Throwing sand is not allowed. If you want to throw, throw a ball."
"Stop breaking the crayons."	"Crayons are for drawing. If you'd like to take things apart, I'll show you a toy we do that to."

Avoid threats	
Threats "If you don't do what I told you, you're going to be in trouble." "If you throw that sand, you'll be sorry." to leave the area."	**Clear expectations** "It's time to come in. You can walk or I can carry you." "Put the sand down or you'll need
Eliminate questions you really don't mean to ask.	
Unclear questions "Will you put coats on?" "Will you come to group time?" "Will you be quiet please?"	**Clear statements** "It's time to put your coat on before we go outside." "You need to find your place in the circle. I have something special to show you."
Offer choices	
Command "You must work at the game center." "Get that gum out of your mouth."	**Choice** "Would you like to work at the game center on a puzzle or with a pegboard." "You can put the gum in some paper and give it to me or throw it in the trash."
Refer to external references	
Personal statement "You must lay on your cot until nap time is over." "I want you to clean up now."	**External reference** "When the long hand is on 3 naptime is over." "After all the centers are cleaned, we will be able to go outside."

ACTIVITY B2
TIME ALLOWANCE 20-30 MIN.

LEARN BY DOING

Procedure	Materials
1. After discussing importance of teaching children new skills to replace inappropriate behaviors, break group in the groups of 3-5 people. 2. Give each group a strategy from handout B9 and have them brainstorm when these strategies could be used and how they have used them. Give each group 10 min. to discuss. 3. Have each group describe strategy and how they've used it in their centers.	Cut Handout B9 in strips with strategy, description, and examples.

ENVIRONMENTAL WORKSHEET

FROM THE ECERS:

Areas of strength: _____

_____

_____

Areas of weakness: _____

_____

_____

Focus on two areas of weakness. Discuss ideas for improving these areas.

List strategies to improve weaknesses: _____

_____

_____

_____

_____

_____

LET YOUR WORDS WORK FOR YOU

After reviewing the "Watch Your Words" handout, read the "Statements We Often Use With Children" and re-think how they could be stated in a clear and positive way. Re-write them in the right-hand column.

Inappropriate statements we often use with children. manner.	How we could say them in a positive, teaching
1. "Stop doing that!"	1. "Here, the blocks go on the shelf like this."
2. "You can't kick people. We don't kick anyone because we don't want anyone to get hurt. If you want to kick, you come up to me and tell me, and I will let you kick in this room back here."	2. Child responds positively. "That's right, just like that!"
3. "Be nice."	
4. "Don't do that or you'll get in trouble."	
5. "Would you like to come over here?"	

THREE SCENARIOS

1. During group language the teacher told Justin to be quiet four times. During the next activity period Justin was ignored while the other children were given choice time if they were quiet. During the following class Justin was quiet the entire period.

   What was the reinforcer?

   What was the punisher?

2. Each morning when Elsie arrives at school she stands by her locker and waits for someone to help her open her locker door, take her jacket off and help her into the classroom. Her teacher helped her the first week of school. The second week of school the teacher decided to see if Elsie would enter the classroom if she was left alone. Elsie stood by her locker until free time was over, then a teacher would help her. On the fifth day she removed her wraps and entered the classroom without any help.

   What was the reinforcer?

   What was the punisher?

3. Amy grabs toys from other children and moves from play center to play center. Her teacher reprimanded her during the first week and decided to place her in time-out during the second week if she grabbed toys from other children. She reduced the amount of toy grabbing but she was in time-out during most of the play time. What could the teacher do in addition to time-out?

   What was the reinforcer?

   What was the punisher?

BEHAVIOR PROBLEM
PROBLEM SOLVING WORKSHEET

1. Describe the general problem. _____

   When does it occur? _____

   Where does it take place? _____

   Why does it occur? _____

2. What changes in the environment could take place to help the child be successful? _____

3. Keep written initial data on the child's behavior (baseline).

   How will it be collected? _____
   When? _____
   Where? _____
   Method of data collection? _____
   During what activity? _____

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Base line					
1st Wk of Treatment					

4. **Behavior to increase.** Describe the behaviors you want to increase.

_____

_____

_____

Behavior to decrease. Describe the behavior you want to decrease.

_____

_____

_____

5. When _____ displays the behavior you want to increase, the adults will do this (select a teaching strategy, as well as a reinforcer to use)?

_____

_____

_____

_____

When _____ displays the behavior you want to decrease, the adults will do this:

_____

_____

_____

_____

6. Keep track of progress on a calendar

7. Review progress each week. Make changes as behavior changes or doesn't change.

REFERENCES

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DEALING

WITH

PARENTS

DEALING WITH PARENTS

SUGGESTED OUTLINE

OBJECTIVES	ACTIVITIES
Participants will:	
1. Have a general understanding of the cycle parents of handicapped children may go through. They will also know: a. The cycle is continuous b. Each parent may go through the cycle at different rates and in different ways.	1.1 Complete Activity D1. It will serve as an impetus to further discussion. 1.2 Review "Parental Reactions" (Handout D1). 1.3 Review "Cycle of Parent's Responses" and "Common Responses of Parents with Special Needs" (Handout D2 and D3). 1.4 Invite a parent who has experienced the cycles, (preferably a parent who has an older child who understands the cyclical process). Meet with the parent before the visit, and review the cycle handout along with suggestions to share a couple of personal experiences. 1.5 Review Assignment D1 together -- discuss the scenarios and relate to what part of the cycle the parent may be in.

2. Will acquire strategies for communicating effectively with different types of parents.	2.1 Review handouts "Communicating with Parents" and "Dealing with Parents: Do's and Don'ts" (Handouts D4 and D5). 2.2 Invite a social worker or psychologist who has a special interest in the area of dealing with parents to be the guest presenter (your local school district or AEA may be able to give suggestions). Meet with the individual before the date they are to attend and review what has already been presented. You may want them to present some of the materials instead of yourself, or the social worker or psychologist could answer questions/or help brainstorm specific questions from the participants (Activity D3).

PARENTAL REACTIONS

IMPACT OF THE EXCEPTIONAL CHILD

How Does it Affect the Family?

The impact of a handicapped child on a family system varies with each family. Much of the research on dealing with parental reactions to having a handicapped child is diverse and sometimes contradictory.

There is some evidence that parents of handicapped children experience some commonalties of feelings.

Parents may go through a series of emotional reactions:

Shock		"The Glooms"	
Refusal		"The Speeds"	
Guilt		"The Blocks"	
Bitterness		"The Hurts"	
Envy		"The Guilts"	
Rejection	(Love,	"The Greats"	(Perske,
Adjustment	1970)	"The Give-Ups"	1973)

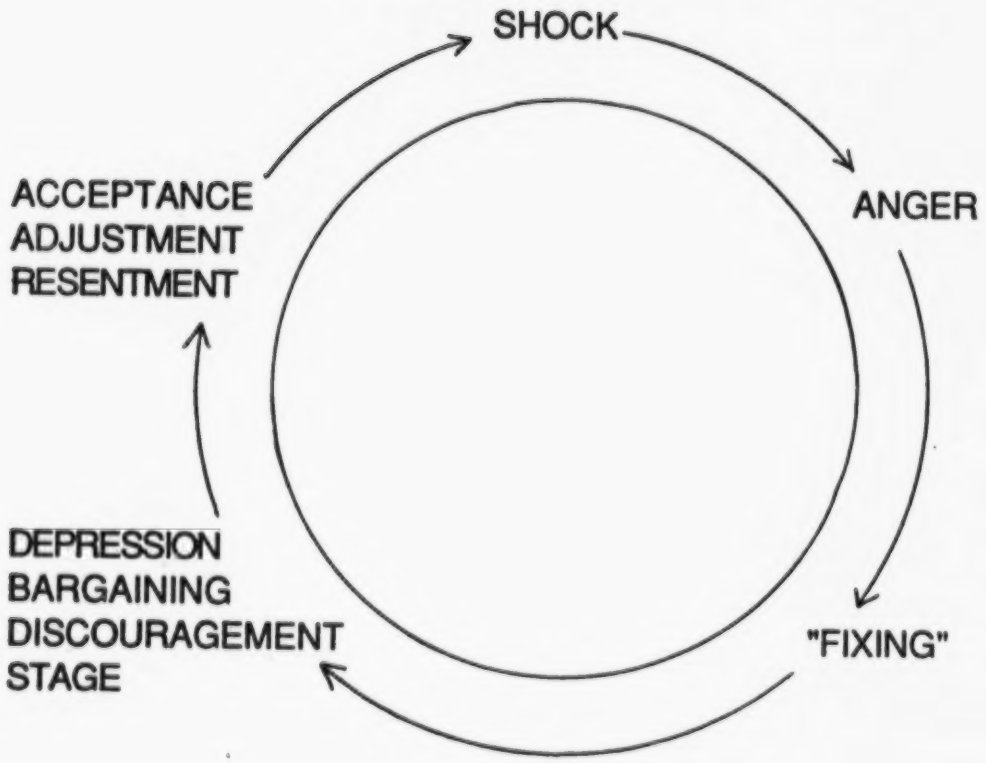
It has been suggested that parents' reactions to having a handicapped child are similar to those reactions to death and dying. As in a death or a person discovering a loved one has a terminal illness, the emotional reaction of a parent to their handicapped child will depend in part on the severity of the handicap, what age the individual is and other factors. The intensity of the reaction will also differ with each family and each situation.

Handout D2 describes the cycle that many parents' feelings follow. The cycle is continuous and may be repeated several times at the advent of a typical life experience (i.e., going to kindergarten, graduation, etc.)

What Can We Do?

Parents generally need other adults to <u>listen</u> (see Handout D3). Parents of handicapped children may re-tell their story or an unfortunate incident several times. Avoid telling about something that has happened to you or giving "solutions." In essence give them support and guide them to trained local resource persons.

CYCLE OF PARENTS' RESPONSES



COMMON RESPONSES OF PARENTS WITH SPECIAL NEEDS CHILDREN

Common Behavior	Parents' Feelings/ Actions	Preschool Workers' Response
Shock **Disbelief** **Denial**	- Denial of handicap - Pretend handicap is not there - Excuses for why child is having "trouble" - Shame, guilt, unworthiness - Overcompensate by intense training - Doctor "hopping" - visits to different doctors to find out what parent wants to hear	- Listen with acceptance - Assure that feelings are normal - Focus on working together with the child - Affirm child's strengths - Direct parents to sources of information, gently
Anger **Resentment**	- May become angry at seemingly insignificant things - Sounds envious of others - Verbally abusive to teachers or others that have taught or been part of the child's diagnosis - May take statements by professionals or others out of context and restate them to the child's advantage	- Listen with acceptance - There is no need to agree or give suggestions - Direct parents to sources of information - Affirm your acceptance of the child and focus on working together - Avoid giving examples of what others have done
Bargaining	- Work hard with the child, i.e., "If I work with him every day he will catch up." - Grasping for straws (postponing acceptance of the child's handicap) i.e., "This is just a stage." "His eyes are crossed - when that's corrected he'll catch-up	- Listen with acceptance - Show caring for child and for the parents
Depression **Discouragement**	- May be more open to suggestion for helping the child - Mourn the loss of the image of "normal child" - Have a sense of helplessness, hopelessness	- Listen with acceptance - Avoid criticism or too much praise - May need to suggest support group, counseling or other local resources.
Acceptance **Adjustment**	- Realizes something positive can be done - Accepts whole child - Adjusts lifestyle - Recognizes needs of child - Learns new techniques	- Teach new training techniques - Praise progress - Encourage realistic expectations

Adapted from: Kantos, S., Dunham, J., et. al. (1987) Neighbor Care: Training Manual for Family Day Care (Grant No. 6008401382).

COMMUNICATING WITH PARENTS

BASIC RULES

1. **Listen** to what the parent has to say before you talk.
2. **Give eye contact.**
3. **Acknowledge and allow negative feelings** of parent, even if they are expressed towards you.
4. **Listen attentively.**
5. **Keep parents informed.**
   Let parents know in a straight-forward manner if there is a problem. On the other hand, let the parent know when there is progress as well.
6. **Deal with the feelings first, then with the content.** Understand that responses are often at an emotional level.
7. **Listen** to what the parent has to say.
8. **Avoid giving advice** unless the parent asks for it.
9. **Reflect** back to parent what they have said to you in clear terms.
10. **Convey respect** for parents, child and their feelings.
11. Remember the parent(s) are **doing the best they can.**

DEALING WITH PARENTS

DO'S AND DON'TS

Parents often come to school to seek help, guidance or information regarding a decision they need to make about their child. This decision can range from allowing their child to go on a field trip to placing the child out of the home. Here are some helpful do's and don'ts when talking to a parent who is facing a crisis with their child.

DO'S

Listen attentively.
Help sort out contradictory information.
Brainstorm alternatives and the consequences.
Be a sounding board, that is, reflect back to the parents what they have said to you in clear terms.
Be supportive of the parent, regardless of the decision, it was probably difficult to make.

DON'TS

Don't make the decision.
Don't tell parents all the things they should do for their handicapped child.
Don't make parents feel guilty or defensive about the things they have not done.
Don't compare their child with other children.
Don't point out all the problems that the child has.
Don't be the expert who knows all the right answers.

The Low Ability Parent

Many of our children have parents who have been in special education classes themselves, or have had some type of learning disability. Here are some suggestions you may find helpful the next time you talk to such a parent:

DO'S

Convey respect--they've been in a one down position most of their life.
Tell them your specific objectives for their child and how you are going about teaching those objectives.
Encourage involvement.
Encourage the parent to talk about what is going on at home and offer helpful suggestions.
Encourage parents to come to school or contact you as often as is feasible.

DON'TS

Don't use educational jargon, which the parent may not understand.
Don't talk down to the parent.
Don't withhold information about the child because you think the parent may not be able to understand.
Don't assume you know more about the child than the parents do--you may be wrong.

The Overprotective Parent

Reasons for overprotection are complex. One possible reason may be fear--fear based on the hunch that the child could hurt himself, but fear based on the feeling that he or she is not a good person or parent if the child does get hurt. Over protection may also stem from fear that he or she may not be needed so much by a more independent youngster. At any rate, overprotection can drive the teacher "up a tree." Here are some suggestions you may find helpful when talking to such a parent:

DO'S

Acknowledge the parent's concern for the child.
Focus in on a specific ability you are teaching the child.
Itemize the ways you are teaching the child and discuss progress.
Involve the parent in planning similar activities at home.
Ask parents if they have time to allow child independence in one specific activity or one specific time.
Check back to exchange progress reports.

DON'TS

Don't accuse parent of babying child.
Don't ask why he is overprotective.
Don't judge the parent--they are doing the best job they know how.
Don't try to force independence on parents and their child.

The Angry Parent

Anger is very difficult for all of us to deal with, especially when it is directed towards us, yet the expression of anger from a parent can be helpful and lead to a fruitful discussion. Below is a suggested list of Do's and Don'ts you may find helpful when you are confronted with an angry parent:

DO'S

Listen to what he is saying.
Acknowledge his anger.
Help focus the problem.
Share your feelings and perceptions.
Brainstorm possible solutions.
Be honest in what you can and cannot do to solve the problem.
Arrive at a tentative solution you can both live with.

DON'TS

Don't defend--it usually leads to escalation of angry feelings.
Don't placate--covered up anger erupts again and again.
Don't rush the process--he needs to be heard out.
Don't attempt to "mold" parents and get them to conform to school...instead explain needs and allow for individuality.

To Deal With Resistance

Remember--resistance is an act of not doing or agreeing with what someone wants done.
Therefore to deal with it, here are some things you may want to do:

List advantages and disadvantages of the proposal.
Site a successful case history.
Do a demonstration.
Suggest a trial period.
Make certain you understand the parent's thoughts and grasp his/her point of view.
Study each objection closely.
Restate the parent's objection...this allows the person to reassess what they have said.
Avoid taking objections too lightly or too seriously.

ACTIVITY D2
TIME ALLOWANCE 15-30 MIN

PINPOINTING THE STAGE

PROCEDURE:

1. Use the Assignment D1 as a role playing experience.

2. If there is a large group, divide into small groups and give each group a scenario from the assignment.

MATERIALS:

Assignment D1

Pencils

ACTIVITY D1
TIME ALLOWANCE 10-15 MIN

UNDERSTANDING PARENTS' FEELINGS

PROCEDURE:

Ask participants to list (allow 2 or 3 minutes):

1. 5 reasons people get married
2. 5 reasons people have children
3. Imagine you're about to have a baby with someone you love. What are your expectations for the child? What do you want the child to be like? (List 5 characteristics.)
4. After months of planning you begin labor and deliver a 6 lb. 10 oz. baby boy. Your doctor reports "There is a problem with your baby; he has down's syndrome." List 5 reactions you might have.
5. Ask participants to share the items they listed on # 1 and 2. Write some of them on the blackboard or large piece of paper.
6. Ask participants to share activities they thought would be affected by having a child with down's syndrome.
7. Ask participants to share how they think having a child with down's syndrome would affect each of the expectations listed under #1, 2 and 3.

MATERIALS:

For each participant:
- paper
- pencils
- blackboard or large paper

Adapted from: Project Rhise Outreach, Children's Development Center, Rockford, Illinois.

ACTIVITY D3
TIME ALLOWANCE 15-30 MIN

I'VE GOT A "DOOZIE"

PROCEDURES:

1. Ask each person to think of a difficult encounter with a parent. (Give the participants a couple of minutes to think.)

2. Share the instances and relate to the categories listed in the "Dealing with Parents" handout.

3. If there is time, role play one of the experiences to practice different ways of responding.

   Discuss.

MATERIALS:

None

STAGES OF PARENTS

3 SCENARIOS

Read each scenario and discuss what stage the parent may be in, and what some appropriate responses might be.

1. Jay has been attending your preschool for eight weeks now. In general, Jay, who is mildly mentally retarded, has fit into your class rather well except he has trouble sitting during any large group time. You have tried a variety of techniques and have recently talked to his parents about your attempts to encourage Jay to stay with the large groups and participate.

   Mr. and Mrs. Jones seem concerned but offer a couple of suggestions and suggest Jay's special education teacher may have some ideas too. They ask if everyone could meet next week and offered to contact Jay's special education teacher.

   What behavior are the parents exhibiting from the grief cycle?

2. Jennifer attends your Head Start class. The parents enrolled her after the local special education team recommended a preschool special education classroom. Jennifer is 4-years-old and rarely says anything. If she does, she says only one or two words. She rarely interacts with other children and it is difficult to get her involved in the activities set up in the room. Jennifer's mother tells you that Jenny isn't talking because she had a lot of ear infections when she was young. She also has explained that Jennifer doesn't play with the other children because she is an only child.

   What behavior from the cycle is the mother exhibiting?

   How could you respond?

3. Alex's father is coming today. You have talked to Alex's mother in the past about some of his problems. The center director and yourself suggested an evaluation from the local school district. Since that time, Alex's father has called with several complaints about your program and with concerns and questions about a lost hat. Mr. Johnson called today and said he wanted to talk to you. He sounded quite angry.

What stage of the cycle do you think Alex's father is in?

What kinds of responses should you prepare yourself for before Mr. Johnson arrives?

HANDICAPPING

CONDITIONS

HANDICAPPING CONDITIONS

This section includes handouts that review different handicapping conditions in general terms. This section is not intended to study in great depths various handicapping conditions, rather it is to give general information and serve as a resource to early childhood centers.

It is not suggested that in-service opportunities concentrate primarily on handicapping conditions as it's primary function. Instead, one session is sufficient to review general categories and examine common factors that are important for the child that has a disability (i.e., independence, getting along with others, expressing needs and wants appropriately). An appropriate time to be more specific about handicapping conditions is when a child is enrolled or about to be enrolled in an early childhood center. At that time, assemble those who are involved, resources (including handouts, etc.) and review issues that are appropriate to the specific child who will be/is attending the regular environment.

A few activities are included at the end of this section for use with large or small groups, or before handouts are reviewed.

HEARING IMPAIRMENTS

DEFINITION

Hearing impairment is a loss of auditory sensitivity ranging from mild to profound which may effect one's ability to communicate with others. Deaf students include those whose hearing impairments are so severe they do not learn primarily by auditory means, even with amplification, and need specialized instruction to develop language, communication and learning skills. Hard of hearing children acquire speech and language by auditory means, although they may experience difficulty in oral communication, language and learning skills with or without amplification, and may need instructional modifications to make full use of educational experiences.

CHARACTERISTICS

Deaf children have unique communication needs. They are unable to hear the continuous, repeated flow of language interchange around them, and are not automatically exposed to enormous amounts of language stimulation experienced by hearing children in their early years.

TIPS

- Always get child's attention before giving a direction
- Demonstrate if directions are not understood
- Wait for responses
- Have child imitate, but don't pressure
- Introduce new words that fit child's activity
- Fill-in or expand on child's incomplete sentences
- Tell child their voice is too loud or soft
- Ask child to repeat or to "show me" if you don't understand
- Reduce noise and clutter
- Provide physical help, if needed

INDICATORS OF POSSIBLE HEARING IMPAIRMENT

Many times you are in the best possible position to find students with a hearing loss. Children should be referred for testing if they show some of the following symptoms:

BEHAVIOR: (A student with a hearing loss in only one ear will not always show these behavior signs. A unilateral loss can be adequately identified only through audiometric testing.)

YES	NO		
---	---	1.	Does not respond when spoken to.
---	---	2.	Often says "huh" or "what" -- requires repetition of a spoken statement.
---	---	3.	Watches speaker's face intently.
---	---	4.	Talks louder or softer than is expected.
---	---	5.	May have a speech and/or language problem.
---	---	6.	Habitually gives irrelevant, wrong or no response to questions.
---	---	7.	Appears unable to follow oral directions.
---	---	8.	Interrupts conversation -- seems unaware others are talking.
---	---	9.	May become irritable or a behavior problem (often because he does not understand others and, therefore, is "corrected" for misunderstanding).
---	---	10.	Uses facial expressions showing confusion, puzzlement, inquiry or disappointment at not having understood what has been said.
---	---	11.	May hold head in an abnormal position, turning one ear toward speaker.
---	---	12.	Seems disinterested, restless or daydreaming. However, appears alert and attentive to things <u>that can be seen</u> rather than to those he is expected to hear.
---	---	13.	Tends to withdraw from group conversations.

HEALTH:

YES	NO		
---	---	1.	Frequent colds, nose and throat infections, allergies.
---	---	2.	Earaches, draining ears.
---	---	3.	Mouth breathers.
---	---	4.	History--serious disease, blow to ears, excessive wax in the ears, sinus infections, swollen glands, infected tonsils and adenoids.
---	---	5.	Seems to develop symptoms of hearing loss following illness or accident.
---	---	6.	Complains of ear pain, fullness in the ear, nausea or dizziness, not being able to hear.
---	---	7.	Child is being followed at the present time by a physician for an ear infection.

Child's Name: _____

Center: _____

For an audiology appointment at no cost, call:
(3 years and over) 262-8372
(under 3 years) 270-4030
You must know your local building name.

VISUALLY IMPAIRED CHILD

DEFINITION

The educational definition of blindness may be different from legal definitions. They are:

Visual handicap - a visual problem that requires a need for special education

Blindness - no vision or minimal vision (light perception). Blind students will eventually need to learn braille or use other non-visual media.

Low vision - limited distance vision. People with limited vision are able to see items close to them and may use a combination of vision and other senses to learn although adaptions in lighting and size of print may need to be used.

WORDS SOMETIMES ASSOCIATED WITH VISUALLY IMPAIRED

Myopia	Visual disturbances
Hyeropia	Visual impairment
Blind	Depth perception

CHARACTERISTICS

The effect of visual problems on a child's development depend on the severity, type of loss, and age of onset and overall developmental functioning of the child.

- May miss normal experiences in the environment because they are unable to see, or see the activity clearly enough.
- Because the child cannot see, he or she will not imitate social behavior or non-verbal cues.
- Some children "play" with their eyelids or push their fingers into their eyes.
- May look down or straight ahead when someone is talking to them.

TIPS

Before child starts at the center, invite parent to bring child when there are no children. Talk child through different parts of the room so the child is familiar with the room and where things are.

- Encourage independence
- Give opportunities to feel, smell or taste real objects
- Avoid rearranging furniture

TIPS (cont'd)

Partially sighted:

- Block out unnecessary light
- Speak and perform demonstration
- Teach colors of common objects
- Use simple, bold colors
- Seat child up close
- Encourage child to hold objects at an angle and distance that is best for seeing
- Praise child for trying

Little or no vision:

- Encourage using what vision they have
- Provide clear explanations of all activities
- Provide concrete experiences; use touch or physically move the child through new activities
- Signal activity changes verbally
- Use multiple sensory experiences
- Gently remove hands from face if child tends to "fiddle" with eyes
- Praise child for trying
- Help child use sound, size and distance clues

PHYSICAL DISABILITIES

DEFINITION

Physical disability describes a medical or structural condition that may disrupt a child's development and require special attention. Physical disabilities often include orthopedic handicaps (i.e., missing limbs or spina bifida).

TERMS ASSOCIATED WITH PHYSICAL DISABILITY

orthopedically handicapped		hemiplegia
spina bifida		quadraplegia
cerebral palsy		muscular distropy

A child with a motor disability may have trouble controlling and coordinating muscle movements, or may have limited use of parts of the body.

TIPS

- Allow child to be as independent as possible - avoid being over protective, or allowing the other children to help too much.
- Let the child do as much of a task as they can. Physically assist them with the rest when time allows.
- Check to see if the chair you're using is the right size. If the child's feet aren't supported, try a box or phone book so they feel more stable.
- Some physically handicapped children have difficulty sitting on the floor, and may be more comfortable sitting on a stool. Other children who are more physically involved may need to be "positioned" in special chairs or equipment which are recommended by an occupational or physical therapist. Positioning a child provides them with the support they need and allows them to use their hands optimally. Ask the therapist when the child should be positioned and for how long a period. Taking a photograph of the child will help the staff remember what the child should look like.
- A therapist can also show you how to lift and carry a child in a way that is beneficial to the child and not harmful to your back.
- Allow adequate time for the child to react. It may take longer for the physically disabled child to speak or move after you have made a request.
- Large instructional materials and toys may be easier for a child with a motor disability to manipulate e.g., large beads, chunky crayons, puzzles with knobs.
- Provide open-ended activities -- children will complete task at their individual level.

ENVIRONMENTAL ADAPTIONS

- Because children with crutches, and braces fall easily, try to keep the floor dry and free of loose dirt.
- Children who use wheelchairs or walkers may need more space to move in the environment. Leave enough room between furniture and equipment to move freely.

MENTAL DISABILITIES

DEFINITION OF MENTAL RETARDATION	Children with mental handicaps are similar to non-handicapped children. They usually go through the same development stages, but at a slower rate (including social and behavioral stages). They have their own individual patterns of strengths and needs. Like all children they enjoy being independent and learn best when they can be successful.
CHARACTERISTICS	These are some characteristics of mentally disabled children. Many may have: - Short attention spans - Difficulty with transitions - Understanding long verbal directions - Responding immediately to questions or directions
WORDS OFTEN ASSOCIATED WITH MENTAL RETARDATION	There are different levels of mental retardation; words that are often associated with mental retardation. - Mental deficiency - Mental handicap - Down's syndrome - Slow learner - Developmental disability - Brain damage
MILD MENTAL DISABILITY	Generally develop about two-thirds to three-quarters the normal rate of development. If a mildly mentally disabled child is 3 to 5-years-old, their skills may be more like a 2 1/2 to 3-year-old. Some children with mild mental disabilities are not delayed at all in gross motor skills, but may not use any speech or language. Some may speak in two or three word phrases, but not be toilet trained. Each child who has a mild mental disability will be a bit different developmentally, depending on their experiences and other possible handicapping conditions.

MODERATE MENTAL DISABILITY	Moderately mentally disabled children develop at about one-half the rate of non-handicapped children of the same age. Language and speech development may be a difficult area for moderately mentally disabled children. Between 3 and 5 years they may be able to understand (receptive language) more than they can say. They should be able to understand "come here," "stop," "give me a hug," "it's time to eat."

TIPS	- Keep verbal directions simple.
	- Using gestures (such as pointing) often helps a child realize what is expected.
	- A child with a learning handicap may need a longer time to understand and respond to directions.
	- Use gentle physical contact and guidance to direct children's attention and behavior, as well as expressing affection.
	- Provide an extra try or two at performing a skill.
	- Warn the child in advance that an activity is going to change to help with classroom transitions.
	- To help focus on learning activities avoid:
	  - instructional materials with confusing backgrounds
	  - tabletops with readily accessible materials that are not being used
	- Break learning tasks into small parts to help child learn each part one at a time.
	- Alternate quiet/active activities, and alternate free play. Organized learning activities may help them pay attention.
	- Like other children, those with learning handicaps learn best when they are rewarded with adult attention and approval of efforts.
	- Give child lots of practice. Repeat the same activity in the classroom, on the playground, and maybe even during snack.
	- Show them how to do something, not just tell.
	- Teach in small steps.
	- Demonstrate the task before children try it.

TIPS (on including a mentally disabled child in your classroom)

- Praise progress, no matter how slow.
- Be accepting and loving.
- Making the child responsible for a part of the classroom routine - make sure the task is something they can do with very little or no assistance.
- Include each child as fully as possible in all activities.
- Give child opportunity to show off accomplishments. When a child is proud of something, show it to others.

Some moderately disabled children between 3 and 5 begin to combine two words and can point to familiar objects.

They should be able to walk well, climb into chairs, and walk with assistance up and down stairs (if they do not have a complicating disability).

They may need assistance with dressing and toileting. They may be messy eaters.

TIPS to remember

- Provide support, <u>but only when they need it.</u> The child should be encouraged to be as independent as possible.
- Avoid treating the child like the "baby" of the group. If the child is 4 and his/her abilities are more like the 3-year-olds, it is OK to put him/her with a group of students with like developmental needs.
- Ask the parents for suggestions and involve them as much as possible.
- Learn the child's <u>strengths,</u> as well as needs.
- Do things or have the child do things they can do on their own or they will be successful at. Every child needs to feel successful and capable.

BEHAVIOR DISORDERS

DESCRIPTION	Children with behavior disorders exhibit one or more of the following characteristics: 1. Inability to learn which cannot be explained by intellectual or health factors 2. Inability to build or maintain satisfactory interpersonal relationships with peers and teachers 3. Inappropriate behavior under normal circumstances Children with autism may also be identified as behavior disordered.
CHARACTERISTICS	Some of the characteristics and behaviors seen in some behavior disordered children include: - Hyperactivity (short attention span, impulsivity) - Aggression/self-injurious behavior (fighting, acting out) - Immaturity (crying, tantruming, poor coping skills) - Withdrawl (failure to imitate interactions with others, excessive fear and anxiety, extreme passivity) Many children who are not emotionally disturbed may display some of the same behaviors at various times during their development. However, a behavior disordered child will display some or all of the behavior more consistently and with more intensity. Documentation of the behaviors is extremely important then, to determine if the behaviors are more intensely and for a longer duration than other children who are at the same age or developmental age. Autistic-like characteristics may include: abnormal ways of relating to people, objects, events; unusually high or low activity levels; insistence that the environment and routine remain the same; use of toys in an unconventional manner; slow development or lack of physical, social, language, learning skills; and repetitive movements. Some of these characteristics may occur in children with other disabilities

WORDS OFTEN ASSOCIATED WITH A BEHAVIOR DISORDER	Behavior disabled Emotionally disturbed Autism
TIPS	The <u>Aggressive Child</u> - Follow a routine for arrivals and departures - Before a transition, give several reminders before announcing count downs to the group - Encourage child to express feelings in words, not actions - Remind child if he/she is losing control, and prompt appropriate behaviors - Give child enough personal space during group activities - Seat child between non-aggressive children - If possible, provide extra space on either side of aggressive child's chair - Control the child's level of stimulation by removing unused materials, slowing down activity, or introduce quiet activity - Watch closely for signs that an assault may take place (i.e., angry looks and threatening words) - involve the child in a different activity The <u>Anxious Child</u> - Prepare child before transition - the child is leaving a familiar and safe, and entering a new situation - Explore new activities or areas beforehand - Set child between non-aggressive children - Don't force participation - Encourage attempts to participate - Help child understand that it is more important to try an activity than to do it perfectly The <u>"Hyper" active Child</u> - Circle time is difficult - call on the child frequently (when they even slightly pay attention). The shorter the time between questions, the less danger there is that the child's attention will wander. - Keep activities shorter initially and gradually lengthen as the year continues. - Alternate activities available. - Avoid "nagging" the child to: i.e., "set down", "be quiet", etc. Instead, try to reinforce when they attend and remember to reinforce others. - If a directive comment is needed, state what you actually want them to do; i.e., say: "Sit in your chair," instead of "Don't do that."

"Hyper" active Child (cont'd)

- Give short, clear and calm directions.
- Provide adult supervision.
- Control level of excitement; remind child when when he or she is losing control.
- Use demonstrations to keep child's attention.
- Don't expect prolonged sitting - break tasks into small segments.

The Withdrawn Child

- Encourage and support participation, but allow child to watch and listen.
- Avoid a lot of coaxing - the child may get more attention for holding back than participating.
- Respond positively to child's attempts to communicate.
- Gradually involve the child in a few simple activities; introduce other children into activity gradually.

The Autistic-like Child

- Most autistic children profit from a structured educational program.
- Break instruction down into small steps.
- If self-stimulatory behavior is interfering with learning, try to find a way to distract or stop it - ignore it during unstructured times.
- Focus on concrete actions - feelings and verbal descriptions may not be understood.
- Change materials often - use different seating arrangements and change routines occasionally.
- Children often respond to positive reinforcement.

CHILDREN WITH AUTISTIC-LIKE BEHAVIOR

DESCRIPTION	Children with autistic-like behavior exhibit one or more of the following characteristics: 1. Inability to learn which cannot be explained by intellectual or health factors. 2. Inability to build or maintain satisfactory interpersonal relationships with peers and teachers. 3. Inappropriate behavior under normal circumstances. Children with autism may also be identified as behavior disordered.
CHARACTERISTICS	Autistic-like characteristics may include: abnormal ways or relating to people, objects, events; usually high or low activity levels; insistence that the environment and routine remain the same; use of toys in an unconventional manner; slow development or lack of physical, social, language, learning skills; and repetitive movements. Some of these characteristics may occur in children with other disabilities.
TIPS	The <u>Autistic-like Child</u> - Most autistic children profit from a structured education program. - Break instruction down into small steps. - If self-stimulatory behavior is interfering with learning, try to find a way to distract or stop it -- ignore it during unstructured times. - Focus on concrete actions - feelings and verbal descriptions may not be understood. - Change materials often - use different seating arrangements and change routines occasionally. - Children often respond to positive reinforcement.

ACTIVITY H1
TIME ALLOWANCE 15-20 MIN.

WATCH OR HELP?

Procedures:

1. Divide group into groups of 5-10.
2. Participants should sit in a circle.
3. The boxes or baskets are placed in the middle of each group. Pencils are scattered on the floor.
4. Trainer has participants draw a card.
5. Directions to "the game".

   Each member of the team picks up 5 pencils and places them in the container in the middle. The first team done wins.

   Say, "those with cards marked with an 'H' are Handicapped. You do not have use of your upper limbs. You may remove shoe and socks. You may not use your hands or upper limbs but can use any other means. Those with 'NH' are not handicapped."

6. Follow-up discussion.

   - Have participants share how they felt.

Materials:

- Box or wastepaper basket (1 per group)
- Index cards - for each group of five to eight mark one or two with an "H" and the remaining cards with a "NH".
- Pencils (preferably unsharpened) - approx. five per participant.

Discussion Questions:

- Did the "H" participants want help from the "NH"'s?
- Did the "NH"'s want to help?
- Did the "H" want to do it themselves?

ACTIVITY H2
TIME ALLOWANCE 15-20 MIN.

MY FINGERS DON'T WORK

Procedures:

1. Participants are asked to put gloves on (opposite hands), and/or tongue depressors taped to fingers on dominant hands.

2. Participants are asked to:
   a. cut paper
   b. tie shoes
   c put on coat or other article of clothing
   d. pick up paper from the floor
   e. write name, address

   Optional: Have some of the participants complete tasks without gloves or sticks.

3. The trainer may wish to stimulate the "impatient" adult.

4. Follow-up discussion could include discussion of frustration participants felt.

Materials:

Either:
   a. a large pair of work gloves
   or
   a. tongue depressors or popsicle sticks
   b. masking tape
   c. scissors and paper
   d. paper and pencil

Questions for discussion:
- What other tasks in your own daily life would be difficult to do?
- What things would be difficult to do in your classroom?
- What word/s would describe your feelings when you were trying to accomplish the task?

WHAT DO I DO?

PROCEDURE:

1. Issue each participant a piece of paper and a pencil.

2. Trainer reads following directions to participants with a straight face. Begin slowly but pick up speed in talking.

   Fold this square piece of paper in two along the diagonal. You now have a triangle - (Pause). Mark a point on the diagonal at one-third of the distance starting from the left angle, and another at the middle of the triangle's left side. Fold the left angle along the line between the two points so that the left angle reaches towards the right side - (Pause). Now draw a point at the middle of the right side, draw another point at one-third of the diagonal starting from the angle of the right, draw a line between those two points, and fold along the line you have just drawn - (Pause). In order to finish the cup, separate the two angles of the paper at the top of the old triangle on each side of the cup. Open the cup.

3. If participants ask for repetition of instructions, trainer should repeat directions in an impatient manner ("Okay, but pay attention this time.")

4. Follow-up discussion should rotate to the participant's personal feelings regarding the activity. Discuss range of reactions the group felt.

5. Break up into groups and have each group list ideas in presenting the activity based on learning strategies.

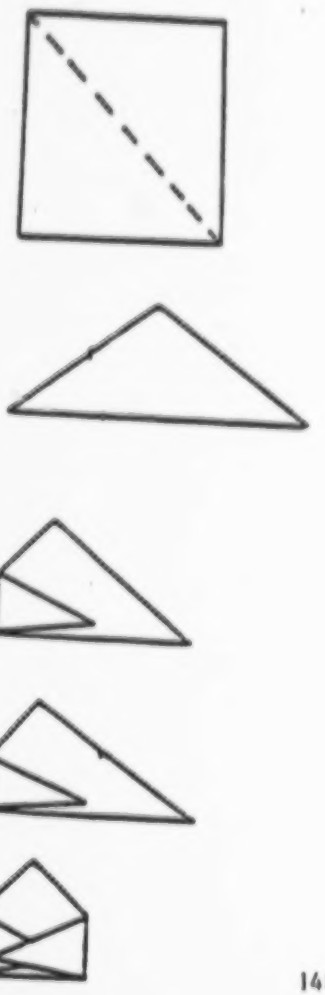
MATERIALS:

For each participant:
Plain 8 1/2" x 11" paper
Pencil

Procedure: (for trainer only)

Diagram: (show group after they have tried)

PAPER FOLDING PROCEDURES



GLOSSARY

GLOSSARY

ACTING OUT - Behavior inappropriate to the situation, usually characterized by a higher intensity of activity, and negative or destructive in nature.

ADAPTIVE BEHAVIOR - Behavior which has been changed to more appropriately fit a given situation. The effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group.

ADVOCACY - Activities relating to support or advice for parents and/or children with handicaps with regard to programming.

AFFECTIVE - Pertains to feelings or emotions.

ANOMALY - Anything unusual, irregular or different from the general rule; usually refers to some physical characteristic. A congenital anomaly is one that happens to a baby before he is born and is usually diagnosed at birth.

ANXIETY - Apprehension, tension or uneasiness that stems from the anticipation of danger, the source of which is largely unknown or unrecognized.

APGAR SCORE - A scale devised by Dr. Virginia Apgar to measure a newborn baby's vital signs at birth and right after birth.

APHASIA - A disorder of language learning; the loss of the ability to express or understand language symbols (the spoken or written word) as a result of some central nervous system dysfunction. It can be expressive (or "motor"), in which the person can understand but cannot give back appropriate responses; receptive (or "sensory"), in which the person cannot understand language he hears or sees; or both. Congenital aphasia means language did not develop at all, rather than it was once developed and then lost.

APRAXIA - Difficulty in motor output, or in performing purposeful motor movements. This medical term reflects an abnormality of the central nervous system.

ARTICULATION - The ability to enunciate speech sounds accurately.

ATAXIA - Muscle incoordination that shows itself, during a purposeful movement, by irregularity and lack of precision.

ATAXIC - Incoordination of motor function and irregularity of muscle action.

ATHETOID - A type of cerebral palsy, characterized by involuntary movements of the muscles, usually involving part of an arm or leg (hand or foot).

ATTENTION SPAN - The extent to which a person can selectively focus his attention on things.

AUTIOLOGIST - The person who is trained to evaluate, diagnose and treat hearing problems.

AUDITORY - Pertaining to hearing.

AUDITORY DISCRIMINATION - The ability to detect subtle differences among sounds in words (tap-cap; cap-cop).

AUDITORY MEMORY - To remember what is heard (words, numbers, stories). This includes both short and long term memory.

AUTISM - The state of being autistic is characterized by a withdrawal from reality, a preference for inanimate objects, desire to be alone. Being solely concerned with self. The autistic child may possess a good memory and be able to repeat verbatim what another person says. It is possible to "warm" an autistic child by one's affection, but some psychologist believe he possesses his own "key" for return to reality. There is a dispute among, and between psychologists, and others in mental health, as to whether autism is organic (inborn) or emotional. The term is often used interchangeably with childhood schizophrenia.

BEHAVIOR MODIFICATION - An approach to changing behavior by understanding and manipulating the external, social or behavioral forces that operate on a person. The belief is that a person is likely to repeat behavior that is followed by a pleasant or gratifying experience. Therefore, emphasis is placed on giving positive reinforcements (rewards) for desirable behavior; a form of operant conditioning.

BINET - Standford - Binet intelligence test.

BRAIN DAMAGE - Any structural or chemical defect of the brain. Such damage could occur before, during or anytime after birth.

BRAIN INJURED CHILD - A child who before, during or after birth has received an injury of the brain. As a result of this, there are disturbances which prevent or hinder the normal learning process.

CENTRAL NERVOUS SYSTEM - The brain and spinal cord make up this mechanism which coordinates and harmonizes the activities of the human body.

CEREBRAL - Referring to the brain.

CEREBRAL PALSY - A general term used to describe several conditions resulting from injury to the brain; usually before or immediately after birth. It varies widely in degree of severity and body parts affected. There are 3 major types:

1. Spastic - one type characterized by increased muscle tone and exaggerated reflexes.
2. Athetoid - another type characterized by constant succession of involuntary movement.
3. Ataxia - loss of muscular coordination.

CHRONOLOGICAL AGE - Sometimes referred to as CA, it means the actual number of years a person has lived.

CLEFT LIP - A congenital defect in which a fissure exists in the upper lip.

CLEFT PALATE - A congenital defect in which a longitudinal fissure exists in the roof of the mouth.

COCHLEA - The cavity of the inner ear which looks like a snail shell.

COGNITION - The act or process of knowing; the various thinking skills and processes are considered cognitive skills.

COGNITIVE - How much one knows. Pertains to thinking.

COGNITIVE ACTIVITIES - Activities during which the ability to think, question and solve problems is utilized.

COMPREHENSION - Knowledge or understanding of an objective, situation, event or verbal statement.

CONDITIONING - A psychological term referring to a method of programming behavior according to a predetermined plan.

CONDUCTIVE HEARING LOSS - Concerned with outer or middle ear, hearing loss due to a blockage or impedance of sound transmission to the inner ear. This type of loss is often responsive to medical or surgical treatment.

CONFIDENTIALITY - With the exception of certain individuals such as school officials and teachers with legitimate educational interests, no one may see the records of a handicapped child unless the parent gives written permission.

CONGENITAL - Any mental or physical trait or condition that exists at birth because of something that happened to the fetus during the time it was in the womb; it may or may not be hereditary.

CONGENITAL HEARING LOSS - A hearing loss which exists at the time of birth.

CONVULSION - Violent, involuntary contracting and relaxing of the muscles; spasms.

CONVULSIVE DISORDER - The term is sometimes used interchangeably with seizure disorder and epilepsy. Generally it includes grand mal, petit mal, psycho-motor and Jacksonian seizures. There are many other types among the epilepsies.

CORTEX - The outer layer of the brain.

CRETINISM - Congenital hypothyroidism with resultant mental retardation. Among the characteristics are delayed skeletal maturation, dry and cold extremities and large tongue.

CROSSING THE MIDLINE - Ability to perform tasks requiring the eyes or hands to cross the midline of the body (i.e., touching the right ear with the left hand).

CYSTIC FIBROSIS - A congenital metabolic disorder in which the body gives off certain abnormal secretions that are carried throughout the body in the blood. Symptoms usually appear in early

childhood. The disease is chronic and degenerative, with no known cure. It is usually found only in Caucasians.

D.P.I. - Stands for the Department of Public Instruction.

DELAYED SPEECH DEVELOPMENT - This is a broad term which refers only to the fact that a child has not acquired speech at the expected time nor with the expected accuracy.

DEPRIVATION (Cultural) - A condition in which the general total environment surrounding a child is markedly inappropriate to enable him to be taught skills needed for coping with the general environment, even though appropriate for the subculture.

DEPRIVATION (Sensory) - A condition in which one or more of the major senses (e.g. vision, hearing) are so impaired as to markedly reduce or restrict use of the sense; in such cases, intellectual retardation may occur, if provisions are not or cannot be made for compensation for the reduced sensory input.

DEVELOPMENTAL - Successive changes during the process of natural growth.

DEVELOPMENTAL DISABILITY - A developmental disability is a severe, chronic disability of a person which: 1) is attributable to a mental or physical impairment or combination of mental and physical impairments; 2) is manifested before the person attains age 22; 3) is likely to continue indefinitely; 4) results in substantial functional limitations in three or more of the following areas of major life activity: a) self-care, b) receptive and expressive language, c) learning, d) mobility, e) self-direction, f) capacity for independent living, and g) economic self-sufficiency; and 5) reflects the person's need for combination and sequence of special, interdisciplinary or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

DIAGNOSTIC SERVICES - Included but not limited to the educational, medical, psychological and the social aspects of the individual that identify the presence of an abnormal mental or emotional or other related conditions. Diagnostic services examine the causes, complications and the consequences of the problem.

DISTRACTIBILITY - Tendency for one's attention to be easily drawn to outside stimuli, or to focus on minor details with a lack of attention to major aspects.

DOMINANCE - The preferred side of the body.

DOWN'S SYNDROME - A commonly recognized form of mental retardation caused by imperfect chromosome formation and characterized by low mentality and abnormal body features.

DWARFISM - Failure to grow to the average or natural size. Erratically stunted growth which may be due to undersecretion of the anterior lobe of the pituitary gland.

DYSFUNCTION - Absence of complete normal function; differs from paralysis in which there is loss of function.

DYSLEXIA - A severe reading disability; an impairment, usually due to central nervous system dysfunction, associated with printed symbols. It is estimated that between 3 per cent to 7

percent of the population of the United States has some dyslexia. Boys seem to outnumber girls almost 3 to 1. The dyslexic child often sees letters or numbers reversed (this is normal in children of a certain age but then passes); he may not be able to tell differences between words that sound somewhat alike; he may have problems with size and shape discriminations (big, small, a square, a circle). All of these factors affect the ability to learn to read.

DYSTROPHY - Weakness and degeneration of muscle.

EARLY EDUCATION - Refers to programming for children as soon as possible. It is hoped that by beginning very early in a child's life, he or she can benefit greatly by achieving more. Many programs begin helping parents and children at birth.

ECHOLALIA - The meaningless repetition of words; the involuntary repetition of a word or phrase just spoken by another person. It is common in the speech of very young children. At a later age, it may be associated with some disorder.

EDUCABLE - An educational term to describe the mildest form of retardation. Also called mildly retarded. Usually the child appears normal until they start school; may be expected to work and live independently.

EEG (Electroencephalogram) - An electroencephalogram, a record of electrical activity of brain, useful in studying some forms of mental or brain disturbance.

ELECTIVE MUTISM - A Selective refusal to speak, independent of intellectual endowment and/or neurological status, occasionally found in retarded children.

EMOTIONAL DEPRIVATION - When reared in the absence of strong emotional feelings or attachment, a child will not or cannot express emotion, and is said to be emotionally deprived.

EMOTIONAL MATURITY - The extent to which an individual in comparison with others of his age level, control his emotional reactions.

EMOTIONALLY DISABLED - Characterized by behavior patterns of withdrawal, explosiveness, hyperactivity or acting out in society.

ENCEPHALITIS - Inflammation of the brain.

EPILEPSY - A neurological disorder characterized by sudden recurrent seizures. A neurological disorder, characterized by a variety of types of seizures. Diagnosis involves an electroencephalogram (EEG), a physical examination, a detailed history and occasionally further tests. MOST epilepsy can be controlled with drugs.

ETIOLOGY - The cause of an illness, disease or condition.

EXCEPTIONAL CHILD - A child who differs intellectually, physically, socially or emotionally to the extent that he cannot receive maximum benefit from a regular school program. He requires a special class of supplementary instruction and services. Sometimes incorrectly used to describe an exceptionally bright child. Correct term would be gifted child.

EXPRESSIVE COMMUNICATION - The actual speech a child utters.

EXTENSION - Straightening of boddy parts; used in therapy reports.

EXTREMITIES - An arm or leg; sometimes specifically hand or foot.

FINE MOTOR - Refers to the control of fine (small) movements such as buttoning a shirt, whistling, cutting with scissors, etc.

FLEXION - Bending; term is used inn therapy reports.

FOCAL SEIZURES - Affects the function of one particular area of the brain.

GAIT - The way one walks. Many brainn damaged children have what is called an "awkward gait."

GENETIC COUNSELING - Assistance in gaining information and/or making decisions concerning the birth of a child who may have certain characteristics affected by the chromosomal pattern of the parents. This information is gained through a study of the family history and chromosomes. This service may pprove helpful to parents or married couples regarding the conception of children or additioonal children.

GESTURE - Nonverbal form of commuunication.

GRAND MAL SEIZURE - Typically, the loss of consciousness, all muscles tightening, usually some jerky movements of legs and arms, the eyes may roll up. Also, frothing at the mouth, wet or soiling themselves, can bite tongues or cheek.

GROSS MOTOR - Refers to coordinnation of large muscles in a purposeful manner such as bouncing a beach ball, jumping, skipping, etc.

HEARING IMPAIRED - A persoon with a loss of hearing of any degree; mild, moderate, severe, profound.

HEARING LOSS (Conductive) - Due to a problem affecting the outer or middle ear. The main problem is lack of acuity; whoen signals are loud enough, they can be received and acted on.

HEARING LOSS (Sensorineurall) - Permanent loss due to damage to either the cochlea, auditory nerve or both. A few of the problems include lack of acuity and poor understanding or discrimination of speech and otherr signals.

HEMIPLEGIA - Paralysis of the arm and leg on one side of the body.

HEREDITY - The characteristics, condditions or traits passed down in a family from parents to children.

HYDROCEPHALUS - Condition chharacterized by abnormal accumulation of fluid within the skull resulting in enlarged head and promminent forehead. When diagnosed early, the enlargement frequently can be halted by surgically inserting a shunt.

HYDROCEPHALLY - A condition of increased secretion of serum into the cranial spaces with a possible consequence of pressure to such a point that the brain may be damaged.

HYPERACTIVE - Hyperkinesis - term used to describe children who are always moving, in constant motion, unable to control activity.

I.E.P. - Stands for Individual Educational Plan. Each child involved in a special education program is required by law to have one of these plans stating goals and objectives for the child. The I.E.P. may be developed cooperatively by teachers, parents, clinicians, therapists and administrators.

I.Q. - (Intelligence Quotient) - Intellectual functioning assessed by standard tests; relative to rest of population in any particular age group.

IMPULSIVE - Acting without thinking, and in uninhibited way.

INATTENTIVE - Inability to focus on any particular activity for any length of time.

INCIDENCE - Range of occurrence or influence of a condition or disease.

INCONTINENT - Having no control over bowel or bladder.

INTEGRATION (Mainstreaming) - The placement of an impaired student in regular classes on a part-time basis.

INTELLIGENCE TEST - A standardized test which gives the statistic indicating one's mental ability. These can be group or individual; the latter must be administered by a trained psychologist.

LANGUAGE, EXPRESSIVE - Speaking and writing.

LANGUAGE, RECEPTIVE - Listening and reading.

LEARNING DISABILITIES - A learning disability is characterized by a significant lag in academic achievement when compared to the ability level as measured by standardized intelligence tests.

LOCOMOTION - Movement from one location to another (walking, rolling, crawling, etc.).

MAINSTREAMING - Placing of children with handicaps within the regular educational system of the school, particularly in the regular classroom.

MEMORY - The function of revising past experience. The ability to store and retrieve, upon demand, previously experienced sensations and perceptions when the original stimulus is no longer present.

MENTAL AGE - The age level of mental ability determined by standardized intelligence tests.

MENTAL DISABILITY - Refers to a level of intellectual functioning. The functioning level is said to be subnormal (significantly below normal); it originates during the developmental period

(infancy and early childhood). Subnormal functioning is associated with defects in either learning and social adjustment or maturation (natural growth). See also Educable, mildly retarded, moderately retarded, moderately retarded/impaired, severely retarded/impaired, trainable retarded/impaired.

MICROCEPHALY - A condition of mental retardation characterized by a head that is greatly diminished in size; generally the face is of near normal size.

MID-LINE - An artificial line running down the center of the body.

MINIMAL BRAIN DYSFUNCTION (MBD) - There is no agreement over the meaning of MBD among those who use it. It is a neurological learning disorder which can affect the receptive, expressive or integrative process - the result of which is a disability, not an incapacity.

MODERATELY RETARDED/IMPAIRED - A mental health term to describe a form of mental retardation. Synonymous with trainable retarded.

MOTOR - Pertaining to muscular activity.

MOTOR ACTIVITIES - a) Gross motor - activities such as walking, running, swimming, climbing stairs, etc., which contribute to development of large muscles and their skills; b) fine motor - activities such as placing pegs in a peg board, stringing beads, cutting with scissors, printing, etc., which contribute to development of small muscles and their skills.

MOTOR PERFORMANCE - The ability to plan and execute fine and gross motor tasks.

MULTIDISCIPLINARY TEAM (M-TEAM) - Refers to a process of bringing together professionals and parents in order to plan a program for a child.

MULTIPLE HANDICAP - Term used to indicate the presence of two or more handicapping conditions.

NEUROLOGICAL EXAMINATION - Tests to determine disease of or damage to the nervous system.

NEUROLOGIST - A physician whose area is neurological problems, or problems of the central nervous system.

NONCATEGORICAL - Refers to a system of grouping handicapped children together without reference to a particular label, category or exceptionality.

NORM - An average, common or standard performance.

NORMALIZATION - A philosophy which stresses that a person who is handicapped should be able to live and experience life at the most normal level possible.

O.T. - Occupational therapy.

OCCUPATIONAL THERAPY - Treatment given to improve movement for daily living.

P.L. 94-142 - The Education for All Handicapped Children Act signed into law in 1975 by President Ford. It requires among other things that handicapped children be educated in the least restrictive environment. It also guarantees due process, and requires a written IEP.

P.T. - Physical therapy.

PARAPLEGIA - Paralysis of lower part of body, including both legs.

PASSIVE MOVEMENT - When an individual has body parts moved through range of motion by outside force.

PERCEPTION - The process of becoming aware of objects, qualities or relations.

PERCEPTUAL MOTOR - A term describing the interaction of the various channels of perception with motor activity. The channels of perception include visual, auditory, tactile, kinesthetic and vestibular.

PERSERVATION - The unusual, uncontrolled persistence of a single act; for example, a child who taps on table top until physically restrained.

PETIT MAL - A form of epilepsy which to the onlooker has the appearance of daydreaming or staring into space for a few moments -- sometimes the eyes blink -- also, slight jerking of the legs or arms occur during this attack. They are mainly a disorder of the young.

PHYSICAL THERAPY - Treatment of disorders of bones and joints, muscles and nerves.

PHYSICAL THERAPIST - A person skilled and specially trained in treatment of the body as prescribed by the physician.

PKU (Phenylketonuria) - A condition due to an inborn error of protein metabolism; a specific enzyme in the blood or liver which metabolizes an amino acid found in many foods is lacking, causing this amino acid to collect in large amount in the blood stream preventing normal mental development.

PRIMITIVE RESPONSES - Or primitive reflexes usually appear in the early months of life and disappear soon thereafter.

PRONE POSITION - Refers to child lying on stomach.

PSYCHOLOGIST - One who employs and applies the knowledge of the science of psychology.

PSYCHOMOTOR SEIZURES - An epileptic attack which is characterized by a variety of abnormal behavioral performances with some alteration of consciousness. There may be picking at the clothes, lip smacking, chewing movements, mumbled speech, purposeless moving of the arms or legs, etc.

QUADRIPLEGIA - Paralysis of the body involving arms and legs.

RECEPTIVE COMMUNICATION - Area of language usage related only to understanding meanings of words. The first step to oral language comprehension.

REHABILITATION - A procedure to restore a person to a condition of good health, or useful and constructive activity.

RESPITE CARE - A program which offers temporary care of children who are handicapped so that their parents can have some free time.

RESOURCE ROOM - A room where a student is placed for a part of his school day for teaching in specific areas. The student is part of a regular classroom. Resource Room may provide services to students from more than one disability area.

Any instructional setting to which a child goes for specified period of time, usually on a regularly scheduled basis. Also referred to as a learning center.

RESOURCE TEACHER - A specialist who works with handicapped children and acts as a consultant to other teachers, providing materials and methods to help children who are having difficulty within the regular classroom. The resource teacher works from a centralized resource room or learning center within a school where appropriate materials are housed.

RIGIDITY - Very stiff movements and posture.

RITALIN - A drug used in treatment of hyperactive children.

SCHOOL PSYCHOLOGIST - A psychologist who applies the science of psychology in the diagnosis and therapeutic intervention in the educational and training procedures.

SCOLIOSIS - An appreciable sideways deviation in the normally straight vertical line of the spine.

SENSORIMOTOR - Motor responses to sensory stimuli (visual, auditory, tactile, etc.). As the child grows and develops, these responses become refined, less random, and thus skilled.

SENSORINEURAL HEARING LOSS - Affecting the inner ear; permanent nerve type hearing impairment.

SEVERELY MENTALLY RETARDED/IMPAIRED - An educational term used to describe the most severe form of retardation. May learn activities of daily living to a limited degree. Will always need supervision. As an adult, may be eligible for a work activity center.

SHUNT - Tube implanted to drain excess fluid from the brain to another part of the body.

SIBLING - A brother or sister.

SLOW LEARNER - A child with social and academic behavior less than usual age level standards; individuals who function intellectually in the range of one to two standard deviations below the test mean (approximately 70 to 90 in terms of I.Q.).

SOCIAL ACCEPTANCE - The ability to get along with one's peers (friends).

SOCIALIZATION - The act or process of relating with one other person or a group of people.

SOCIAL HISTORY - The story of the child and his family, facts and feelings.

SOCIAL WORKER - A person trained in insight into human motivation and behavior in the treatment of emotional or social problems.

SPASM - Sudden tightening of muscles.

SPECIAL EDUCATION - Is designed to meet the individual needs of children who deviate from the "normal" or "average" either physically, mentally, socially or emotionally; to the degree that necessitates different methods, materials, techniques, and equipment in order that he may profit from his educational experiences.

SPECIAL EDUCATION CLASS - An instructional setting in which a child spends the major part of every day; children are assigned on the basis that they satisfy the criteria for one of the fundable categories of a handicap; for example, mental impairment, emotional disturbance or lack of educational opportunity. The problem seems to reflect lack of neurological organization.

SPECIAL EDUCATION TEACHER - A teacher who teaches or treats a child who has difficulty in learning. Specialized materials and methods are used.

SPEECH/LANGUAGE CLINICIAN - Persons trained to provide analysis of diagnosis and therapy for speech and language disturbances.

SPINA BIFIDA - Development defect in the body encasement of the spinal cord. This defect leaves the child with varying degrees of impairment of the orthopedic, urologic and neurologic systems. Many possess normal intelligence and all can benefit from professional team approach to care.

STAFFING - Refers to discussion of a child's abilities to aid in program planning.

SUPINE POSITION - Refers to child lying on back.

SYMMETRICAL - Both sides of the body acting the same.

TACTILE - Sense of touch.

TASK ANALYSIS - Refers to breaking down an activity into smaller steps.

TEAM APPROACH - A group of professionals (teachers, therapists, nurses, etc.) who combine their skills, knowledge and work together to plan an individual, prescriptive program to best develop the potential of the whole child.

TONE - Firmness of muscles.

TRAINABLE - An educational term used to describe a person who has potential for self-care, social adjustment and usefulness within the community. Will always need some form of supervision.

As an adult, may be able to perform unskilled tasks in the community or work in a sheltered workshop.

VESTIBULAR STIMULATION - Therapeutic technique used in the remediation of sensory integrative dysfunctions; involves such activities as rapid spinning, rolling, etc.

VISUAL ACUITY - Sharpness of vision.

VISUAL MEMORY - Ability to remember past visual experiences.

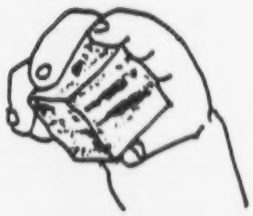
VISUALLY IMPAIRED - Having problem seeing and being able to differentiate accurately meaningful objects in one's field of vision.

W-SITTING POSITION - Refers to child sitting with knees bent, child is resting on haunches (inappropriate position).

WEIGHT-BEARING - On a joint or joints may be inhibitory or facilitatory to the muscles surrounding -- body weight or less is inhibitory, more than body is facilitatory.

MOTOR TERMINOLOGY

PALMER GRASP



INTERMEDIATE GRASP

MATURE GRASP

PRONE

SUPINE

ATNR
ASYMMETRICAL TONIC NECK REFLEX

WORKING WITH PHYSICALLY HANDICAPPED CHILDREN

LIFTING AND CARRYING
(TO MINIMIZE STRESS ON ADULT'S BACK)

To pick up a child with physical handicaps, first roll the child to her side and bring her head and shoulders forward as you bend her hips.

Hold child close and support her head properly. Guide to sitting position before beginning to lift child.

Straighten back. Lift child with legs, rather than back, to minimize stress on back.

When carrying a small child with poor head control, hold child on hip. Your arm should support back.

SITTING POSITIONS

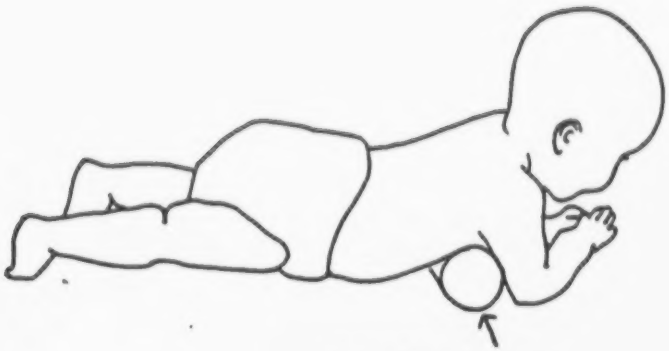
Adult Assisted Sitting

Side Sitting

Cross-legged Sitting

W Sitting
(W-sitting should be discouraged)

MISCELLANEOUS POSITIONS



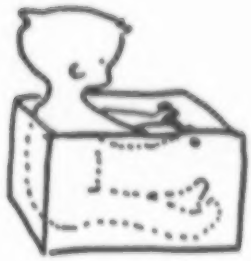
PRONE ON ELBOWS

KNEELING AT TABLE
OR OTHER STABLE
STRUCTURE

SUPPORT AT FEET
WHILE IN SITTING
POSITION

RESOURCES

SEATING ADAPTIONS



These adaptions should be done only under the direction of an occupational or physical therapist.

INFORMATION ON HANDICAPPING CONDITIONS

The following handouts regarding handicapping conditions are from The National Center for Handicapped Children and Youth. The handouts may be copied. If you wish to be on their mailing list, write to:

NICHCY
P.O. Box 1492
Washington, D.C. 20013

In addition, handouts from the March of Dimes are also included. Extra copies can be acquired by contacting:

March of Dimes
1275 Mamaroneck Ave.
White Plains, NY 10605

Special Parent Special Child, Practical pointers for parenting handicapped children bi-monthly newsletter by:

Lindell Press, Inc.
P.O. Box 462
South Salem, NY 10590

NICHCY
NATIONAL INFORMATION CENTER FOR HANDICAPPED CHILDREN AND YOUTH
P.O. BOX 1492 WASHINGTON, D.C. 20013

Visual Impairments

Definitions

The terms "legally blind", "partially sighted", and "low vision" may mean different things in legal and educational contexts. The educational definitions of the terms are given below:

- Visual handicap indicates that some type of visual problem has resulted in a need for special education.
- Blindness refers to a condition with no vision or only minimal vision (light perception). Blind students learn via Braille or other non-visual media.
- Low vision refers to limited distance vision. People with low vision are able to see items close to them. They use a combination of vision and other senses to learn, although they may require adaptations in the lighting or size of print.

Visual impairments can include myopia, hyperopia, and astigmatism; problems in the visual field; and muscular problems that result in visual disturbances.

Incidence

The rate at which visual impairments occur in the general population increases considerably with age, especially after 65. For individuals under 45, the estimated incidence is 7 per 1,000; for individuals over 65, it is 44.5 per 1,000.

Characteristics

The effect of visual problems on a child's development depends on the severity, type of loss, age at which the condition appeared, and overall functioning level of the child. The child may be delayed in motor, cognitive, and/or social development.

A young child with visual handicaps has little reason to explore interesting objects in the environment, and thus may miss opportunities to have experiences and to learn. This lack of exploration may continue until hearing becomes motivating or until intervention begins.

Because the child cannot see parents or peers, he or she may be unable to imitate social behavior or understand nonverbal cues. Visual handicaps can create obstacles to a growing child's independence.

Educational Implications

The student with visual impairments should be tested early in order to assess remaining vision. Mainstreaming has been a successful way of serving the academically oriented student with visual handicaps. These students may need additional help with special equipment and modifications in the regular curriculum to emphasize listening skills, communication, orientation and mobility, vocation/

career, and daily living skills. Students with low or limited vision may need help in using their residual vision more efficiently and in working with special aids and materials. Students who have visual handicaps combined with other types of handicaps may have greater need for an interdisciplinary approach and may require greater emphasis on self care and daily living skills. It is important that all members of the school team and parents understand the child's physical capabilities and limitations. To promote growth, parents and teachers should avoid overprotection and encourage children to take risks within the limits of safety and health. Teachers and classmates should also understand that, although children with visual impairments and children who are blind are handicapped, they are more like their classmates than different from them.

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Ferrell, Kay A. *Parenting Preschoolers: Suggestions for Raising Young Blind and Visually Impaired Children*. 1984. (The American Foundation for the Blind, 15 W. 16th Street, New York, NY 10011)

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P.O. BOX 1492 WASHINGTON, D.C. 20013

Speech and Language Impairments

Definitions

Speech and language impairments refer to problems in communication. Examples include fluency problems (called dysfluency or commonly, "stuttering"), articulation problems, voice disorders, and aphasia (a difficulty using words, usually as a result of brain injury).

The development of speech and/or language may be delayed due to many factors, including environment or hearing loss. Sometimes speech or language impairments may result from other conditions, such as learning disabilities, mental retardation, and cerebral palsy.

Prevalence

Five percent of school aged children are estimated to have speech and language disorders. The number of students identified with delayed speech decreases steadily as children mature.

Characteristics

A child with delayed communication is noticeably behind his or her agemates. Frequently a child will have greater receptive (understanding) than expressive (speaking) language skills. In that case, children may be able to follow directions but have problems producing comprehensible speech or correct syntax and articulation. (Syntax refers to the order of words in a sentence, articulation refers to how sounds are formed. Articulation disorders are characterized by substituting one sound for another such as "wabbit" for "rabbit," by omitting sounds such as saying "han" for "hand," or by distortions such as saying "thay" for "say".)

Students whose primary language is different from standard English may have difficulty communicating in the majority language.

Stuttering, a disorder of speech flow, most often appears between ages 3 and 4 and may progress from a periodic to a chronic problem. Although many children who stutter recover by puberty or early adolescence, speech and language therapy should be considered.

Physical problems, such as cleft lip or palate, may result in difficulties with certain sounds or with control of the voice quality. Articulation problems, a very common form of speech disorder, result in omissions, substitutions, or distortions of sounds.

Typical voice disorders include hoarseness, breathiness, or sudden breaks in loudness or pitch. Frequently, voice disorders are combined with other speech problems to form a complex communication disorder.

Educational Implications

Language experiences are central to a young child's development. Because they introduce and interpret the world to their children via language, parents play a crucial role in stimulating interest and skills with words.

Speech and language therapists function in a support role for teachers of children with communication handicaps. Sometimes therapists remove a child from the class for individual speech therapy, although many therapists now consult with teachers about the best ways to help the child in the regular class setting. The same kinds of helpful techniques may be shared with the parents, so the improvement approach is consistent at home and at school.

Many speech and language "problems" are part of a child's normal development in learning to talk. They become problems when the child is seriously behind his or her same age friends. If you are concerned about a child's speech or language, consult a speech and language therapist. In all cases, it is important to remember that children with speech and language impairment are more like their classmates than different from them.

Technology can help children whose physical conditions make communication difficult. The use of electronic communication devices allows even severely physically disabled people to engage in the give and take of shared thought.

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Resources

American Cleft Palate Educational Foundation
Parent Liaison Committee
Louisiana State University Medical Center
Department of Audiology and Speech Pathology
3735 Blair
Shreveport, LA 71103

American Speech Language and Hearing Association
10801 Rockville Pike
Rockville, MD 20852

Association for Children and Adults with Learning Disabilities
4156 Library Road
Pittsburgh, PA 15234

Division for Children with Communication Disorders
c/o The Council for Exceptional Children
1920 Association Drive
Reston, VA 22091

National Easter Seal Society
2023 West Ogden Avenue
Chicago, IL 60612

National Institute of Nerological and Communicative Disorders and Stroke
National Institutes of Health, HHS
Building 31, Room 8A—06
Bethesda, MD 20205

Prescription Parents (Cleft Lip/Palate)
P. O. Box 426
Quincy, MA 02269

Trade Research and Development Center for the Severely Communicatively Handicapped
314 Waisman Center
1500 Highland Avenue
Madison, WI 53706

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General Information About Handicaps and People with Handicaps

Definition

The regulations for Public Law 94-142 (The Education for All Handicapped Children Act) list 11 types of handicaps:

1. DEAF
   A hearing impairment so severe that the child is impaired in receiving linguistic information through hearing, with or without amplification.
2. DEAF-BLIND
   Simultaneous hearing and visual impairments, whose combination causes such severe communication and other developmental and educational problems that the child cannot be accommodated in special education programs designed soley for deaf children or blind children.
3. HARD OF HEARING
   A hearing impairment, whether permanent or fluctuating, which is less severe than the definition of "deaf" in this section.
4. MENTALLY RETARDED
   Below average general intellectual functioning existing along with deficits in adaptive behavior and manifested during the developmental period.
5. MULTIHANDICAPPED
   Several simultaneous impairments (such as mental retardation and blindness; mental retardation and orthopedic impairments; and so forth), the combination of which causes such severe educational problems that the child cannot be accommodated in special education programs designed solely for one of the impairments. (This definition does not include a deaf-blind child.)
6. ORTHOPEDICALLY IMPAIRED
   A severe orthopedic impairment, including an impairment caused by a birth defect (e.g., clubfoot, absence of an extremity), an impairment caused by disease (e.g., poliomyelitis, bone tuberculosis), and impairment from any other cause (e.g., cerebral palsy, amputations, and fractures or burns which cause contractures).
7. OTHER HEALTH IMPAIRED
   An autistic condition manifested by severe communication and other developmental and educational problems; or limited strength, vitality, or alertness, due to chronic or acute health problems such as heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes.
8. SERIOUSLY EMOTIONALLY DISTURBED
   A condition in which the individual exhibits one or more of the following characteristics over a long period of time and to a marked degree: An inability to learn which cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems. (This definition includes children who are schizophrenic.)
9. SPECIFIC LEARNING DISABILITY
   A disorder of one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual handicap, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include a learning problem which is primarily the result of a visual, hearing, or motor handicap, of mental retardation, or of environmental, cultural, or economic disadvantage.
10. SPEECH IMPAIRED
    A communication disorder, such as stuttering, impaired articulation, a language impairment, or a voice impairment.
11. VISUALLY HANDICAPPED
    A visual impairment, with or without correction. The definition includes both partially sighted children and blind children.

Prevalance

In the school year 1981-82, over 4.2 million children received special education and related services in public schools.

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Resources

Alexander Graham Bell Association for the Deaf
3417 Volta Place, N.W.
Washington, D.C. 20007

American Coalition of Citizens with Disabilities
1200 15th Street, N.W.
Washington, DC 20036

American Council for the Blind
1211 Connecticut Avenue, N.W.
Suite 506
Washington, DC 20036

American Federation for the Blind
15 West 16th Street
New York, NY 10011

American Speech-Language-Hearing Association
10801 Rockville Pike
Rockville, MD 20852

Association for Children and Adults with Learning Disabilities
4156 Library Road
Pittsburgh, PA 15234

Association for Persons with Severe Handicaps
7010 Roosevelt Way, N.E.
Seattle, WA 98115

Association for Retarded Citizens U.S.
National Headquarters
P.O. Box 6109
2501 Avenue J
Arlington, TX 76011

Association for the Care of Children's Health
3615 Wisconsin Avenue
Washington, DC 20016

Council for Exceptional Children
1920 Association Drive
Reston, VA 22091

Down's Syndrome Congress
1640 West Roosevelt Road
Chicago, IL 60608

Epilepsy Foundation of America
4351 Garden City Drive
Landover, MD 20785

Goodwill Industries of America
9200 Wisconsin Avenue, N.W.
Bethesda, MD 20814

March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605

Mental Health Association
1800 North Kent Street
Arlington, VA 22209

National Association of the Deaf
814 Thayer Avenue
Silver Springs, MD 20910

National Easter Seal Society
2023 West Ogden Avenue
Chicago, IL 60612

National Society for Children and Adults with Autism
1234 Massachusetts Avenue, N.W.
Suite 1017
Washington, DC 20005

National Spinal Cord Injury Association
369 Elliot Street
Newton Upper Falls, MA 02164

Spina Bifida Association of America
343 South Dearborn Street
Suite 319
Chicago, IL 60604

United Cerebral Palsy Association
66 East 34th Street
New York, NY 10016

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Mental Retardation

Definition

Persons with mental retardation are those who mature at a below average rate and experience unusual difficulty in learning and social adjustment. The American Association on Mental Deficiency (AAMD) provides the following technical definition, which is widely accepted.

"Mental Retardation refers to significantly subaverage general intellectual functioning in or associated with impairments in adaptive behavior and manifested during the development period."

Intellectual functioning is defined by a score on an IQ test. Persons with mental retardation usually score below 70, or in specific cases, based on new definition, below 75. Adaptive behavior refers to the person's adjustment to everyday life. Difficulties may occur in learning communication, social, academic and vocational skills. The amount of difficulty experienced will depend upon the person's age or development stage. The developmental period is from birth to age 22.

The AAMD definition does not mention prognosis or cause of mental retardation. Although there are more than 250 specific identified causes, in most cases the exact reasons for retardation are unknown.

Mental retardation is not a disease, nor should it be confused with mental illness. Mentally retarded children grow into mentally retarded adults; they do not remain "eternal children." The big difference is that they learn more slowly and with much greater difficulty.

Incidence

Depending upon the definition and measurement approach used, estimates of mentally retarded persons in the general population range from 1% (when relying on the adaptive behavior measurement) to 3% (when the IQ score is emphasized).

According to data reported to the U.S. Department of Education by the states, in the 1983-84 school year, 750,534 students with mental retardation were provided services by the public schools. This number represents 1.86% of the school enrollment.

About 89% persons with mental retardation are mildly retarded; about 6% are moderately retarded; and about 5% are severely or profoundly retarded.

Many authorities agree that individuals with mental retardation develop in the same way that nonretarded persons do, but at a slower rate, and reach a lower overall level of functioning. Others suggest that persons with retardation have difficulties in particular cognitive areas, such as attention, perception or memory. Depending on the extent of the retardation—mild, moderate, severe, or profound—individuals will develop differently in academics, social, and vocational skills.

Mildly retarded persons are in many respects quite similar to their nonretarded peers. While still young their retardation is not readily apparent. Moderately retarded persons are more obviously handicapped, and their retardation is usually apparent before school age. Severely or profoundly retarded persons have obvious intellectual impairments and frequently have other handicaps such as cerebral palsy, epilepsy, blindness, or deafness.

Appropriate educational opportunities beginning in infancy and continuing throughout the development period will allow retarded children to develop to their fullest potential. They can enter the competitive labor market and the mainstream of daily life. Persons with retardation can learn to care for their basic needs and can perform useful work with supervision.

Educational Implications

Persons with mental retardation have the capacity to learn, to develop, to grow. The great majority of retarded persons can become productive and full participants in society. As with all education, individualization is the starting point for successful learning. Throughout their child's education, parents should be an integral part of the planning and teaching team.

In teaching persons with retardation, it is important to:

- Use concrete materials,
- Proceed in small sequential steps and to review each step frequently,
- Provide prompt and consistent feedback, and
- Stress the child's success.

Simple everyday tasks that nonretarded persons learn without instruction need to be structured and specifically taught to persons with retardation. Similarly, tasks should be presented so that the students are able to apply what they have learned to other situations. Special care should be taken to obtain and hold the students' attention.

Children and adults with retardation need the same basic services that other human beings need for normal development. These include education, vocational preparation, health services, recreational opportunities, and many more. In addition, many persons with retardation need specialized services to meet extraordinary needs. Such services include diagnostic and evaluation centers, special early education opportunities beginning with infant stimulation and continuing through preschool, additional day training after completing school with an emphasis on independent living and vocational skills, sheltered employment, assistance in obtaining full employment, and community living opportunities.

Other Considerations

Recent scientific development conclude that preventive measures are effective in reducing the incidence of retardation. Some specific approaches to prevention include:

- Being sure that women are vaccinated for rubella at least three months before they become pregnant,
- Providing proper prenatal care for the mother-to-be, including attention to diet and providing the infant with an adequate diet,
- Checking for Rh factor incompatibility between mother and infant and preventing harm when it occurs by exchanging the baby's blood at the time of birth and providing special immunization for the mother, and
- Preventing children from eating paint containing lead and providing quick treatment if lead poisoning does occur.

Mental retardation has been defined traditionally as an irreversible condition. However, recent advance in technology have been such that there are strong indications that it may be possible within the foreseeable future to significantly enhance intellectual functioning and to reverse certain deteriorative processes. With the application of the current development of new knowledge, the scientific community is working to seek cures for disorders and conditions that cause mental retardation.

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Resources

American Association on Mental Deficiency
5101 Wisconsin Avenue, N.W., Suite 405
Washington, DC 20016

Council for Exceptional Children
Division on Mental Retardation
1920 Association Drive
Reston, VA 22091

International League of Societies for the Mentally Handicapped
12 Rue Forestiere
Brussels 5, Belgium

National Association for Retarded Citizens/US
P. O. Box 6109
2501 Avenue J
Arlington, TX 76011

National Head Injury Foundation
18A Vernon Street
Framingham, MA 01701

People First International
(Self Advocacy Group)
P. O. Box 12642
Salem, OR 97304

President's Committee on Mental Retardation
U.S. Department of Health & Human Services
Office of Human Development Services
Washington, D.C. 20006

Special Olympics, Inc.
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Washington, DC 20006

The Association for Persons with Severe Handicaps
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Seattle, WA 98115

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Down Syndrome

Definition

Down syndrome is the most common and readily identifiable genetic condition associated with mental retardation. It is caused by a chromosomal abnormality: for some unexplained reason and typically due to no one's fault, accident in cell development results in 47 instead of the usual 46 chromosomes. This extra genetic material changes the orderly development of body and brain.

Incidence

Approximately 4,000 children with Down syndrome are born in the U.S. each year, about 1 per 1,000 live births. Although parents of any age may have a child with Down syndrome, the incidence is higher for children born to women and men over 35. Most common forms of the syndrome do not usually occur more than once in a family.

Characteristics

There are over 50 clinical signs of Down syndrome, but it is rare to find all or even most of them in one person. Some common characteristics include:

- poor muscle tone
- slanting eyes with folds of skin at the inner corners (called epicanthic folds)
- white ("Brushfield") spots in the iris of the eye
- transverse crease on the palm (Simian crease)
- flat bridge of the nose
- short neck
- small head
- small mouth
- heart disorders in approximately ⅓ of people with Down syndrome
- a tendency to respiratory infections

Educational Implications

Shortly after a diagnosis of Down syndrome is confirmed, parents are encouraged to enroll their child in an infant stimulation/early childhood education program. These programs offer special instruction in the acquisition of language and teach specific exercises for gross and fine motor development while also working on cognitive, self-help, and social skills. Research has shown that stimulation during early developmental stages improves the child's chances of developing to his or her fullest potential. Continuing education, family involvement, and a stimulating home environment have also been found to have a positive effect on the child's overall development.

Children with Down syndrome develop in different ways and at different paces. Their level of retardation may range from mild to severe with the majority functioning in the mild range. Due to these individual differences it is impossible to predict their future school achievement.

The same general principles of instruction for any child with retarded development apply to a child with Down syndrome. Emphasis is placed on concrete rather than abstract concepts. Tasks and activities are taught in a step by step manner and prompt consistant feedback is continually reinforced. Children with Down syndrome must be helped to learn everyday tasks that non-handicapped children learn incidentally. It is important that all members of the school team and the parents understand the child's capabilities and limitations. To promote growth, parents and teachers should avoid overprotection and encourage children to take risks within the limits of safety and health. Teachers and classmates should also understand that children with Down syndrome are more like their classmates than they are different from them.

Medical/Health Implications

There is a wide variation in mental abilities, behavior and developmental progress in individuals with Down syndrome just as in the "normal" regime.

Individuals with Down syndrome are usually smaller than their "normal" peers and their physical as well as intellectual development is slower. Approximately one-third of babies born with Down syndrome have heart defects, most of which are now successfully correctable by surgery. Some individuals with Down syndrome are born with gastro-intestinal tract problems that can be surgically corrected.

A lowered resistance to infection makes children with Down syndrome more prone to respiratory problems.

Eye problems such as crossing and far or near sightedness are higher in the population with Down syndrome while hearing problems may result in mild to moderate hearing loss and speech difficulty.

Some individuals with Down syndrome suffer from a condition known as Atlantoaxial Dislocation. A misalignment of the top two vertebrae of the neck, this condition makes these individuals more prone to injury if they participate in activities which over extend or flex the neck. Parents are urged to have their child examined by a physician in order to determine whether or not their child should be restricted from sports and exercise activities which place stress on the neck. Although this misalignment is a potential serious condition, if properly diagnosed these individuals can be protected from serious injury.

Children with Down syndrome may have a tendency to become obese as they grow older. This weight gain has negative implications for the individuals' later health and longevity. A supervised diet and exercise program may help reduce this problem.

Older individuals with Down syndrome have been found to age prematurely. This aging process has become more apparent since the recent increase in the life span of individuals with the syndrome. There may be a connection between Down syndrome and the eventual appearances of Alzeheimer's disease, although further research needs to be done.

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National Down Syndrome Society. Pamphlet: This Baby Needs You Even More. (National Down Syndrome Society, 70 West 40th Street, New York, New York 10018) Free.

Resources

Association for Retarded Citizens, United States
2501 Avenue J
Arlington, TX 76011
(817) 640-0204

Caring
P.O. Box 196
Milton, WA 98354
(206) 922-8194

~~National Down Syndrome Congress~~
~~1640 W. Roosevelt Road~~
~~Chicago, IL 60608---~~
~~(312) 226-0416~~

~~National Down Syndrome Society~~
~~146 East 57th Stree~~
~~New York, NY 1002~~
~~Hotline (800) 221-4602~~
~~NY only (212) 764-3070~~

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(312) 823-7550
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National Down Syndrome Society
70 West 40th Street
New York, New York 10018
(212) 764-3070
(800) 221-4602

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Physical Disabilities and Special Health Problems

Definitions

Orthopedic or physical disabilities describe medical or structural conditions which may be serious enough to disrupt the child's development and require special attention in school. Typical examples of orthopedic or physical problems include disabilities present at birth (such as missing limbs, spina bifida, etc.), as well as physical problems resulting from other causes (such as contractures caused by burns or fractures, etc.). In addition, neurological problems, such as cerebral palsy, may be included in this category.

Health impairments may result in limited strength, vitality and/or alertness. Asthma, cardiac conditions, sickle cell anemia, epilepsy, and leukemia are examples of health impairments that could interfere with a child's education.

Prevalence

One half of one percent (.5%) is the figure usually cited in estimates of school aged children with physical or health impairments. Cerebral palsy accounts for a large part of this percentage, followed by spina bifida.

Characteristics

Physical disabilities can produce a variety of characteristics. Children may experience a wide range of restrictions on their activity, from little or none to a complete restructuring of daily life. The most severly affected children may require intensive medical and educational help.

Physical problems may interfere with children's motor functioning, communication, learning skills, or social development.

Educational Implications

The contributions of such related services as physical, occupational, and speech and language therapy are often central to the education of children with physical disabilities. The greatest progress is achieved when therapy suggestions are consistently applied in the child's home as well as in school. This carryover strengthens appropriate feeding, positioning, and language stimulation patterns.

Architectural factors must be considered. Section 504 of the Rehabilitation Act of 1973 requires that programs receiving Federal funds make their programs accessible. This could mean structural changes (for example, adding elevators or ramps) or schedule or location changes (for example, offering a course on the ground floor).

Sometimes the nature of the child's disability requires changes in school equipment or curriculum. In the same way as a student's placement should be the least restrictive one appropriate for him or her, the day-to-day school pattern also should be as "normal" as possible.

Physical disabilities can have profound effects on children's emotional and social development. To promote growth, parents and teachers should avoid overprotection and encourage children to take risks within limits of safety and health. Teachers and classmates should also understand that, although children with physical disabilities and health impairments may be physically handicapped, they are more like their classmates than different from them.

Technology holds great promise for making the life of a child with a disability more "normal." Computerized devices, for example, can help nonvocal, severely physically involved children communicate, perhaps for the first time.

Students who require recurring or longterm hospital care for their condition may need special services such as tutoring or homebound instruction to keep up with their class. Depending upon the nature and severity of the condition, counseling for the entire family may be helpful.

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Resources

Accent on Information
P.O. Box 700
Gillum Road and High Drive
Bloomington, IN 47701

American National Standards Institute
1430 Broadway
New York, NY 10018
(212) 354-3300

American Coalition of Citizens with Disabilities
1346 Connecticut Avenue, NW
Washington, DC 20036
(202) 785-4265

Cancer Information Clearinghouse
National Cancer Institute
Bethesda, MD 20205
(301) 496-4070

The Candlelighters Foundation
2025 I Street, NW - Suite 1011
Washington, DC 20006
(202) 659-5136

Division on Physically Handicapped
c/o The Council for Exceptional Children
1920 Association Drive
Reston, VA 22091

Epilepsy Foundation of America
4351 Garden City Drive
Landover, MD 20785
(301) 459-3700

March of Dimes Birth Defects Foundation
P.O. Box 2000
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100

National Association of the Physically Handicapped
76 Elm Street
London, OH 43140
(614) 852-1664

National Easter Seal Society
2023 W. Ogden Avenue
Chicago, IL 60612
(312) 243-8400

National Library Service for the Blind and Physically Handicapped
Library of Congress
1291 Taylor Street, NW
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National Rehabilitation Information Center
4407 Eighth Street, NW
Washington, DC 20017

United Cerebral Palsy Association
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(212) 481-6300

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Learning Disabilities

Definition

The regulations for Public Law 94-142 (The Education for All Handicapped Children Act) define a learning disability as "disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or to do mathematical calculations."

The Federal definition further states that learning disabilities include "such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia." According to the law, learning disabilities do not include learning problems that are primarily the result of visual, hearing, or motor handicaps; mental retardation; or environmental, cultural, or economic disadvantage. Definitions of learning disabilities also vary among states.

Having a single term to describe this category of children with handicaps reduces some of the confusion, but there are many conflicting theories about what causes learning disabilities, how many children with learning disabilities there are, and so on. The label "Learning Disabilities" is all-embracing; it describes a syndrome, not a specific child with specific problems. The definition is comprehensive; it assists in classifying children, not teaching them. Parents and teachers need to concentrate on the individual child. They need to observe both how and how well the child performs, to assess strengths and weaknesses, and to provide and invent ways to help each child learn. It is important to remember that there is a high degree of interrelationship and overlapping among the areas of learning. Therefore, children with learning disabilities may exhibit a combination of characteristics. These problems may mildly, moderately, or severly impair the learning process.

Prevalence

Many different estimates of the number of learning disabled children have appeared in the literature (ranging from 1% to 30% of the general population). Differences in estimates perhaps reflect variations in the definition. The most widely cited estimate is that 2% to 3% of school-aged children and youth are learning disabled.

Characteristics

Students who have learning disabilities may exhibit a wide range of traits, including problems with reading comprehension, spoken language, writing, or reasoning ability. Hyperactivity, inattention, and perceptual coordination problems may also be associated with learning disabilities, but are not examples of it. Other traits that may be present include a variety of symptoms of brain dysfunction, such as uneven and unpredictable test performance, perceptual impairments, motor disorders, and such emotional characteristics as impulsiveness, low tolerance for frustration and problems in handling day to day situations.

One of the most apparent characteristics of learning disabilities is a significant difference in the child's achievement in some areas, as compared to his or her overall intelligence.

The major learning disabilities occur in four categories:

1. Spoken language: Delays, disorders, and deviations in listening and speaking.
2. Written language: Difficulties with reading, writing, and spelling.
3. Arithmetic: Difficulty in performing arithmetic functions or in comprehending basic concepts.
4. Reasoning: Difficulty in organizing and integrating thoughts.

Educational Implications

Because learning disabilities are manifested in a variety of behaviour patterns, the Individual Education Program (IEP) must be designed carefully. A team approach is important for educating the child with a learning disability, beginning with the IEP process and continuing with close collaboration among special class teachers, parents, resource room teachers, regular class teachers, and others.

Some teachers report that the following strategies have been effective with some students who have learning disabilities:

- High structure and clear expectations
- The use of short sentences and a simple vocabulary
- Opportunities for success in a supportive atmosphere
- Flexibility in classroom procedures (e.g., allowing the use of tape recorders for note-taking and test-taking when students have trouble with written language)

- Use of self-correcting materials that provide for immediate feedback without embarrassment.

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Resources

Association for Children and Adults with Learning Disabilities
4156 Library Road
Pittsburgh, PA 15234
(412) 341-1515 or 8077

Closer Look
LD-TEELINE
800-522-3458 (800-TEL-PREP in Maryland)
A toll-free information and referral service for parents of learning-disabled teens, educators and teens themselves.

Division of Learning Disabilities
The Council for Exceptional Children
1920 Association Drive
Reston, VA 22091
(703) 620-3660

Foundation for Children With Learning Disabilities (FCLD)
P.O. Box 2929
Grand Central Station
New York, NY 10016
(212) 687-7211

National Network of Learning Disabled Adults (NNLDA)
806 North 82 Street #F2
Scottsdale, AZ 85257

Orton Dyslexia Society
742 York Road
Baltimore, MD 21204
(301) 296-0232
(800) 222-3123

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Cerebral Palsy

Definition

According to the United Cerebral Palsy Association, cerebral palsy is a group of disabling conditions caused by damage to the central nervous system. "Cerebral" refers to the brain, while "palsy" describes lack of muscle control that is often (but not always) a nervous system symptom. Cerebral palsy can be mild or severe.

Damage to the brain may occur before or during birth because of illness in pregnancy, premature delivery, or lack of oxygen supply to the baby; or it may occur early in life as a result of an accident, lead poisoning, illness, child abuse, or other factors.

Incidence

Approximately 700,000 Americans (or 16 out of every 5,000) have some degree of cerebral palsy. 10,000 babies with the disorder are born each year, and another 2,000 acquire it in the early years of life.

Characteristics

Four main descriptions of cerebral palsy have been identified:

1. Spastic, the most common type, which results in tense, contracted muscles;
2. Athetoid, which is characterized by constant uncontrolled movements; and
3. Ataxic, which is typified by poor sense of balance and depth perception.
4. A combination of the types of cerebral palsy listed above.

The effects of cerebral palsy depend on the extent and location of the brain damage. One or more of the following conditions may occur:

- seizures
- problems in vision, hearing or speech
- abnormal sensation or perception
- mental retardation
- impairments in arm and leg movement

Educational Implications

Early identification of cerebral palsy can lessen developmental problems and lead to appropriate treatment when it helps the most. Special educators and physicians have discovered that early intervention can make an important difference. Early intervention programs enlist parents and other family members in working with the child in specific activities. These activities, designed by therapist, provide the child with stimulation needed to overcome slower development which is part of cerebral palsy. Other forms of treatment of children with cerebral palsy may include speech and language therapy, occupational therapy, physical therapy, medical intervention and social services.

Among the services that the older child with cerebral palsy may need are: attendant care, continuing therapy, special education, counseling, vocational training, and recreation training. The services required will vary from person to person depending on the nature and severity of the handicap.

Important advances have taken place in the last decade which have a great affect on the long term well-being of children born with cerebral palsy. Advanced technology is being applied to the needs of severely disabled persons with cerebral palsy, including biofeedback, computers and engineering devices. Technological innovations made have been made in the areas of speech and communication, self-care, and adapting jobs. The future may bring even more significant applications.

Another other important development has been an increased ability of disabled persons, including those who are severely disabled, to live independently in the community. Independent living opportunities exist in the form of group, shared and supervised apartments, and of disabled individual living on their own in the community with appropriate support services. Independent Living Centers staffed and run by persons with disabilities have proven to be important resources for disabled persons. Treatment of cerebral palsy requires close cooperation among educational, medical and social services, the family and the individual. To promote growth, parents and teachers should avoid overprotection and encourage children to take risks within the limits of safety and health. Teachers and classmates should understand that, although children with cerebral palsy are physically handicapped, they are more like their classmates than different from them.

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Resources

Information on Cerebral Palsy

United Cerebral Palsy Associations
66 East 34th Street
New York, NY 10016
(212) 481-6300

National Easter Seal Society
2023 West Ogden Avenue
Chicago, IL 60612
(312) 243-8400

National Institute for Neurological and Communicative Disorders and Stroke
National Institute of Health, HHS
Building 31, Room 8A-06
Bethesda, MD 20205
(301) 496-5751

Information of Special Education

ERIC Clearinghouse on the Handicapped and Gifted
Council for Exceptional Children
1920 Association Drive
Reston, VA 22091
(703) 620-3660

Information on Equipment for Children with Disabilities

ABELEDATA
c/o National Rehabilitation Information Center
4407 8th Street NE
Washington, DC 20017
(202) 635-5090

Accent on Information
P.O. Box 700
Gillum Road and High Drive
Bloomington, IL 61701
(309) 378-2961

Information on Design of Accessible Facilities

Adaptive Environments Center
Massachusetts College of Art
26 Overland Street
Boston, MA 02215
(617) 266-2686

Information on Communication Aids

Trace Center Research and Development Center
314 Waisman Center
1500 Highland Avenue
Madison, WI 53706
(608) 262-6966

Information on Rehabilitation and Independent Living

National Rehabilitation Information Center
4407 8th Street, N.E.
Washington, DC 20007
(202) 635-5822

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Epilepsy

Definition

According to the Epilepsy Foundation of America, epilepsy is a physical condition that occurs when there is a sudden, brief change in how the brain works. When brain cells are not working properly, a persons consciousness, movement, or actions may be altered for a short time. These physical changes are called epileptic seizures. Epilepsy is therefore sometimes called a seizure disorder. Epilepsy affects people in all nations and of all races.

Some people can experience a seizure and not have epilepsy. For example, many children have convulsions from fevers. These febrile convulsions are one type of seizure. Other types of seizures not classified as epilepsy include those caused by an imbalance of body fluids or chemicals or by alcohol or drug withdrawal. A single seizure does not mean the person has epilepsy.

Incidence

About 2.5 million Americans have epilepsy. Of the 100,000 new cases that develop each year, three quarters of them are in children and adolescents.

Characteristics

Although the symptoms listed below are not necessarily indicators of epilepsy, it is wise to consult a doctor if you or a member of your family experiences one or more of them:

- "Blackouts" or periods of confused memory;
- Episodes of staring or unexplained periods of unresponsiveness;
- Involuntary movements of arms and legs;
- "Fainting spells" with incontinence or followed by excessive fatigue;
- Odd sounds, distorted perceptions, episodic feelings of fear that cannot be explained.

Seizures can be generalized, meaning that all brain cells are involved. One type of generalized seizure consists of a convulsion with a complete loss of consciousness. Another type looks like a brief period of fixed staring.

Seizures are partial if the brain cells not working properly are limited to one part of the brain. Partial seizures may produce periods of automatic behaviour and altered consciousness.

Educational Implications

Epilepsy is defined as one of the potentially handicapping conditions in P.L. 94-142, The Education for All Handicapped Children Act. A student with epilepsy doesn't necessarily require a special education placement unless he or she also has some other special need such as a learning disability or mental retardation. In these instances, the epilepsy or related conditions may then interfere with the child's ability to learn.

If a child's physical or intellectural skills seem markedly altered since the seizures began, tell your doctor. There may be an associated hearing or perception problem caused by the brain changes. In addition, if a child has the type of seizure characterized by a brief period of fixed staring at school, he/she may be missing parts of what the teacher is saying. Ask your child's teacher to observe and document these episodes.

It's important that teachers understand about the child's condition, possible effects of medication, and what to do in case a seizure occurs at school. Most parents find that a friendly conversation with the teacher(s) at the beginning of the school year is the best way to handle the situation. Even if a child has seizures that are largely controlled by medication, it is still best to notify the school staff about the condition.

Children and youth with epilepsy must deal with the psychological and social aspects of the condition; this includes its lifelong nature, uncertain occurrence, loss of self control, and negative attitudes towards the condition.

School personnel and parents should work together to monitor the effectiveness of medication as well as any side effects. Their written observations will be helpful to the neurologist.

Individual decisions must be made regarding a child's participation in physical activities. It is important that both parents and teachers avoid overprotection. Teachers and classmates should also understand that, although children with epilepsy may have special needs, they are more like their classmates than different from them.

There are many materials available for parents and teachers, so that they can understand how to work most effectively together. The student will benefit the most when both teachers and parents are working together.

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Resources

Epilepsy Foundation of America
4351 Garden City Drive
Landover, MD 20785
(301) 459-3700

Epilepsy Information Line
University of Washington-Seattle
Toll Free Information Line:
(800) 426-0660

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AUTISM

Definition

According to the National Society for Children and Adults with Autism (NSAC), autism is a severely incapacitating developmental disability that usually appears during the first three years of life.

Prevalence

The rate of prevalence, or how often autism occurs in children, ranges from five to fifteen out of 10,000 births. The different estimates are based on slightly different definitions of autism.

It is four times more common in boys than girls and is rarely found in more than one child in a family.

There appear to be several causes of autism, each with distinct neurological effects. Among these causes are untreated phenylketonuria, rubella, celiac disease, and chemical exposures in pregnancy. No known factors in the psychological environment of a child have been shown to cause autism.

Characteristics

Sometimes infants show autistic behaviors from birth: they appear aloof, resist cuddling and show no interest in their surroundings. Children usually have average appearances. Typical characteristics include:

- absent or delayed speech and language, including immature speech rhythms, limited understanding, and use of words without attaching usual meanings.
- abnormal ways of relating to people, objects, and events
- unusually high or low activity levels
- insistence that the environment and routine remain unchanged
- use of toys and objects in unconventional manners
- slow development or lack of physical, social, and learning skills
- repetitive movements such as rocking and spinning, head banging, and hand twisting.

It should be noted that these characteristics may occur in children with other disabilities. Sometimes the term "autistic-like" behavior is used.

Educational Implications

Early diagnosis of autism is very important, but appropriate help given at any age can make a big difference.

The child or youth with autism appears to profit from a high degree of structure in the educational program. Such programs frequently stress social and language skills, with instruction broken down into small, sequential steps.

Although the majority of children with autism are severely delayed in learning, most can learn academic skills and social functioning in an appropriate program.

Many parents and teachers have found that behavior modification can assist the child in developing appropriate behavior.

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Resources

Institute for Child Behavior Research
4157 Adams Avenue
San Diego, CA 92116

National Clearinghouse for Mental Health Information
National Institute of Mental Health, HHS
15C-17 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

National Society for Children and Adults with Autism
1234 Massachusetts Avenue, NW
Suite 1017
Washington, DC 20005-4599

NSAC Bookstore
1234 Massachusetts Avenue, N.W.
Suite 1017
Washington, DC 20005-4599

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Emotional Disturbance

Definition

Many terms are used to denote severe behavior problems (emotional handicaps or disturbances, behavior disorders, psychological disorder, social maladjustment, delinquency, schizophrenia, mental illness, and psychosis). However, most people would agree that each of these terms indicate behavior that is significantly different from what is expected of someone at a particular age.

Public Law 94-142, The Education for All Handicapped Children Act, defines serious emotional disturbance as "a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:

- An inability to learn which cannot be explained by intellectual, sensory, or health factors;
- An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
- A general pervasive mood of unhappiness or depression; or
- A tendency to develop physical symptoms or fears associated with personal or school problems" (*U.S. Federal Register* 42, August 23, 1977, pp. 42478-424-79).

The *Federal Register* definition includes children who are schizophrenic. The law excludes socially maladjusted children (except those determined to be seriously emotionally disturbed) and autistic children (who are included in the "other health impaired" category).

Incidence

For the school year of 1983-84, 362,073 children and youth with emotional disturbance were provided services in the public schools (Seventh Annual Report to Congress, U.S. Department of Education, 1985).

Characteristics

The causes of emotional disturbance have not been adequately determined. Although various factors such as heredity, brain disorder, diet, stress, and family functioning have been suggested as possible causes, research has not shown any of these factors to be the direct cause of behavior problems. Some of the characteristics and behaviors seen in disturbed children include:

- Hyperactivity (short attention span, impulsivity);
- Aggression/self-injurious behavior (acting out, fighting);
- Withdrawal (failure to initiate interaction with others, retreat from exchanges of social interaction, excessive fear or anxiety;
- Immaturity (inappropriate crying, temper tantrums, poor coping skills);
- Social maladjustment (truancy, delinquency); and
- Learning problems (deficits in academic achievement.

The profoundly disturbed child is typically identified as psychotic or schizophrenic. His or her behavior tends to show distorted thinking, excessive anxiety, bizarre motor acts, and frequent mood changes.

Many children who are not emotionally disturbed may display these same behaviors at various times during their development. However, when a child is emotionally disturbed, these behaviors continue over long periods of time. The child's behavior thus signals that the child is not coping with the environment or peers and, in fact, may be bringing harm to himself or herself, and/or to others.

Education

Educational instruction for children with emotional disturbances may be similar to the programming provided to other handicapped children. Major objectives include developing social skills and increasing self-control. Other goals in addition to teaching basic self-care may include teaching basic self-care skills. Career education (vocational programs) is rapidly becoming a major part of secondary education for those children, and is recommended as part of every adolescent's individualized education program (IEP).

Behavior modification is one of the most widely used approaches to teaching children with emotional/behavioral disorders. This approach increases appropriate behaviors and decreases inappropriate behaviors by using the principles of reinforcement and shaping. Art, music, play, and drama therapies have been helpful to some children. Most professionals consider a well structured program to be vitally important when working with disturbed children, regardless of the particular approach chosen. It is important that teachers and parents react as consistently as possible.

The approaches described above together with extra

support for teachers have allowed more children with emotional disturbances to be educated in the public schools in the past. Programs are moving towards intensive, short-term intervention rather than specialized placements. The focus of intervention is early detection and prevention.

Other Considerations

Families of children with emotional disturbance may need help in understanding their child's condition and in learning how to work effectively with him or her. Help is available from psychiatrists or psychologists in public or private mental health settings. Sometimes it is necessary to remove the child from the home and to obtain residential care. Each child should be provided services based on his or her individual needs and all persons who are involved with the child should be aware of the care he or she is receiving, that is, it is important to coordinate all services with communication between home, school, and the therapeutic community.

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Kaufman, J. M. (1981). *Characteristics of Children's Behavior Disorders*. (Charles E. Merrill Co., 1300 Alum Creek Drive, Columbus, OH 43216)

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Twiford, R. (1979). *A Child with a Problem: A Guide to Psychological Disorders of Children*. (Prentice-Hall International, Inc., 301 Sylvan Avenue, Englewood Cliffs, NJ 07632)

Resources

American Association of Psychiatric Services for Children
1522 K Street, N.W.
Suite 1112
Washington, DC 20005

(Provides information on meetings and professional journals)

Council for Children with Behavior Disorders
c/o Council for Exceptional Children
1920 Association Drive
Reston, VA 2209

(Distributes a fact sheet on emotional disturbance)

Mental Health Association
1800 North Kent Street
Arlington, VA 2220[illegible]

(Offers referral services to parents. Some affiliates provide parent support services)

National Alliance for the Mentally Ill
1200 15th St., N.W.
Washington, DC 20005

(Distributes literature on emotional and behavioral problems. State affiliates provide support services)

National Clearinghouse for Mental Health Information
National Institute of Mental Health
15C-17 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

(Distributes literature on schizophrenia and depression as well as child development)

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.laudet College/National Information Center on Deafness
NICD/NAD

DEAFNESS: A FACT SHEET

FROM THE NATIONAL INFORMATION CENTER ON DEAFNESS AND THE NATIONAL ASSOCIATION OF THE DEAF

Introduction

An estimated 16 million Americans have some degree of hearing impairment. Hearing impairments affect individuals of all ages, and may occur at any time from infancy through old age. The degree of loss may range from mild to severe. This variability in age at onset and degree of loss plus the fact that each individual adjusts differently to a loss of hearing makes it impossible to define uniformly the consequences of a loss.

Of the 16 million Americans who are hearing impaired, over two million are considered deaf. These individuals have hearing losses so severe that they cannot hear or understand either speech or most of the sounds in our everyday environment, even with the help of a hearing aid. The other 14 million hearing impaired Americans have less severe losses and often can be helped to understand speech through the use of a hearing aid.

Audiological/Medical Information

There are four types of hearing loss, each of which can result in different problems and different possibilities for medical and non-medical remediation.

Conductive hearing losses are caused by diseases or obstructions in the outer or middle ear (the conduction pathways for sound to reach the inner ear). Conductive hearing losses usually affect evenly all frequencies of hearing and do not result in severe losses. A person with a conductive hearing loss usually is able to use a hearing aid well, or can be helped medically or surgically.

Sensorineural hearing losses result from damage to the delicate sensory hair cells of the inner ear or the nerves which supply it. These hearing losses can range from mild to profound. They often affect certain frequencies more than others. Thus, even with amplification to increase the sound level, the hearing-impaired person perceives distorted sounds. This distortion accompanying some forms of sensorineural hearing loss is so severe that successful use of a hearing aid is impossible.

Mixed hearing losses are those in which the problem occurs both in the outer or middle and the inner ear.

A **central** hearing loss results from damage or impairment to the nerves or nuclei of the central nervous system, either in the pathways to the brain or in the brain itself.

Among the causes of deafness are heredity, accident, and illness. An unborn child can inherit hearing loss from the parents. In about 50% of all cases of deafness, genetic factors are a probable cause of deafness. Environmental factors (accident, illness, ototoxic drugs, etc.) are responsible for deafness in the remaining cases. Rubella or other viral infections contracted by the pregnant mother may deafen an unborn child. Hazards associated with the birth process (for example, a cut-off in the oxygen supply) may affect hearing. Illness or infection may cause deafness in young children. Constant high noise levels can cause progressive and eventually severe sensorineural hearing loss as can tumors, exposure to explosive sounds, heavy medication, and/or injury to the skull or ear.

Central hearing loss may result from congenital brain abnormalities, tumors, or lesions of the central nervous system, strokes, or some medications that specifically harm the ear.

The detection and diagnosis of hearing impairment have come a long way in the last few years. It is now possible to detect the presence of hearing loss and evaluate its severity in a newborn child. While medical and surgical techniques of correcting conductive hearing losses have also improved, medical correction for sensorineural hearing loss has been more elusive. Current research on a cochlear implant which provides electrical stimulation to the inner ear may lead to important improvements in the ability to medically correct profound sensorineural hearing loss.

Educational Implications

Deafness itself does not affect a person's intellectual capacity or ability to learn. Yet, deaf children generally require some form of special schooling in order to gain an adequate education.

Deaf children have unique communication needs: unable to hear the continuous, repeated flow of language interchange around them, deaf children are not automatically exposed to the enormous amounts of

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language stimulation experienced by hearing children during their early years. For deaf children, early, consistent, and conscious use of visible communication modes (such as sign language, fingerspelling, and Cued Speech) and/or amplification and aural/oral training can help reduce this language delay. Without such assistance from infancy, problems in the use of English typically persist throughout the deaf child's school years. With such assistance, the language learning task is easier but by no means easy.

This problem of English language acquisition affects content areas as well. While the academic lag may be small during the primary grades, it tends to be cumulative. A deaf adolescent may be a number of grade levels behind hearing peers. However, the extent to which hearing impairment affects school achievement depends on many factors—the degree and type of hearing loss, the age at which it occurred, the presence of additional handicaps, the quality of the child's schooling, and the support available both at home and at school.

Many deaf children now begin their education between ages one to three in a clinical program with heavy parent involvement. Since the great majority of deaf children—over 90%—are born to hearing parents, these programs provide instruction for parents on implications of deafness within the family. By age four or five, most deaf children are enrolled in school on a full-day basis. Approximately one-third of school-age deaf children attend private or public residential schools. Some attend as day students and the rest usually travel home on weekends. Two-thirds attend day programs in schools for the deaf or special day classes located in regular schools, or are mainstreamed into regular school programs. Some mainstreamed deaf children do most or all of their schoolwork in regular classes, occasionally with the help of an interpreter, while others are mainstreamed only for special activities or for one or two classes.

In addition to regular school subjects, most programs do special work on communication and language development. Class size is often limited to approximately eight children to give more attention to the children's language and communication needs.

At the secondary school level, students may work toward a vocational objective or follow a more academic course of study aimed at postsecondary education at a regular college, a special college program for deaf students (such as Gallaudet College or the National Technical Institute for the Deaf), or one of the 100 or more community colleges and technical schools that have special provisions for deaf students.

Communication: Some Choices

Communication is an important component of everyone's life. The possible choices for communication involve a variety of symbol systems. For example, you may communicate in English through speaking and writing. Despite your skills, you probably cannot communicate with someone whose only language is Chinese, even though that person also speaks, reads, and writes quite fluently.

In the United States, deaf persons also use a variety of communication systems. They may choose among speaking, speechreading, writing, and manual communication. Manual communication is a generic term referring to the use of manual signs and fingerspelling.

American Sign Language

American Sign Language (ASL) is a language whose medium is visible rather than aural. Like any other language, ASL has its own vocabulary, idioms, grammar and syntax—*different from English*. The elements of this language (the individual signs) consist of the handshape, position, movement, and orientation of the hands to the body and each other. ASL also uses space, direction and speed of movements, and facial expression to help convey meaning.

Fingerspelling

When you spell with your fingers, you are in effect "writing in the air." Instead of using an alphabet written on paper, you are using a manual alphabet, that is, one with handshapes and positions corresponding to each of the letters of the written alphabet.

Conversations can be entirely fingerspelled. Among deaf people, however, fingerspelling is more typically used to augment American Sign Language. Proper names and terms for which there are no signs are usually fingerspelled. In the educational setting, the use of fingerspelling as the primary mode of communication in combination with spoken English is known as the Rochester method.

Manual English

When the vocabulary of the American Sign Language and fingerspelled words are presented in English word order, a 'pidgin' results. Pidgin Sign English (PSE) is neither strictly English nor ASL, but combines elements of both.

A number of systems have recently been devised to assist deaf children in learning English. These systems supplement some ASL signs with invented signs that correspond to elements of English words (plurals, prefixes, and suffixes, for example). There is usually a set of rules for word (sign) formation within the particular

Educational Institutions

Schools for deaf students have traditionally played an important role in advancing the welfare of deaf people through education of deaf students and public information efforts about the capabilities and accomplishments of deaf people. Two national institutions each have enrollments of over 1,000 deaf students.

Gallaudet College
800 Florida Avenue, NE
Washington, DC 20002

National Technical Institute for the Deaf
Rochester Institute of Technology
1 Lomb Memorial Drive
Rochester, NY 14623

For descriptions of the more than 100 postsecondary programs for deaf students at community colleges and technical schools around the country, order a copy of **College and Career Programs for Deaf Students** for $3.50 from:

College and Career Guide
c/o Gallaudet Research Institute
Center for Assessment and Demographic Studies
800 Florida Avenue, NE
Washington, DC 20002

Special Devices for Deaf People

Technology and inventiveness have lead to a number of devices which aid deaf persons and increase convenience in their daily lives. Many of these devices are commercially available under different trade names.

Telecommunications Devices for Deaf People (TDDs) are mechanical/electronic devices which enable people to type phone messages over the telephone network. The term TDD is generic and replaces the earlier term TTY which refers specifically to teletypewriter machines. Telecaption adapters, sometimes called decoders, are devices which are either added to existing television sets or built into certain new sets to enable viewers to read dialogue and narrative as captions (subtitles) on the TV screen. These captions are not visible without such adapters.

Signalling Devices which add a flashing and/or vibrating signal to the existing auditory signal are popular with hearing impaired users. Among devices using flashing light signals are door "bells", telephone ring signallers, baby-cry signals (which alert the parent that the baby is crying), smoke alarm systems. Alarm clocks may feature either the flashing light or vibrating signal.

Some Special Services

Numerous social service agencies extend their program services to deaf clients. In addition, various agencies and organizations—either related to deafness or to disability in general—provide specific services to deaf people. Among these special services are the following:

Captioned Films for the Deaf
A loan service of theatrical and educational films captioned for deaf viewers, Captioned Films for the Deaf is one of the projects funded by the Captioning and Adaptations Branch of the U.S. Department of Education to promote the education and welfare of deaf people through the use of media. This branch also provides funds for closed-captioned television programs, including the live-captioned ABC-TV news.

Registry of Interpreters for the Deaf, Inc.
A professional organization, RID maintains a national listing of individuals skilled in the use of American Sign Language and other sign systems and provides information on interpreting and evaluation and certification of interpreters for deaf people

State Departments of Vocational Rehabilitation
Each state has specific provisions for the type and extent of vocational rehabilitation service, but all provide vocational evaluation, financial assistance for education and training, and job placement help

Telecommunications for the Deaf, Inc.
TDI publishes an international telephone directory of individuals and organizations who own and maintain TDDs (telecommunications devices for deaf people) for personal or business use.

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Revised 1984 by Loraine DiPietro, Director, National Information Center on Deafness, Gallaudet College

with ease of communication and compatibility encouraged by shared experiences as deaf individuals leads to socializing with other deaf individuals in maturity. Many deaf people (80%) tend to marry other deaf persons; most of their children (approximately 90%) are hearing.

The Deaf Community

Because the problem in dealing with the hearing world is one of communication, deaf persons tend to socialize together more than do persons with other disabilities. However, members of the deaf community have contacts with other people, too. Some are active members of organizations of hearing people. Some deaf people move freely between hearing and deaf groups, while other deaf people may have almost no social contact with hearing people. A few deaf people may choose to socialize only with hearing people.

While it is possible to find deaf individuals in every section of the United States, there are major concentrations of deaf persons in the larger metropolitan areas of the East and West Coasts.

Organizations of and for Deaf Persons

Clubs and organizations of deaf persons range in purpose from those with social motives (watching captioned films, for example) to those with charitable aims. Organizations offer deaf persons the opportunity to pursue a hobby (athletics, drama) or civic commitment (political action) on the local, regional or national level. Local or state associations of deaf persons may be affiliated with the National Association of the Deaf. The Oral Deaf Adults Section of the Alexander Graham Bell Association for the Deaf has local chapters that provide social opportunities for deaf people who favor oral communication. The National Fraternal Society of the Deaf with insurance, social and charitable objectives, has 120 divisions throughout the United States and Canada.

A few of the more than 20 national organizations of and for deaf persons in the United States are briefly described in the following listing. Many of these organizations publish newsletters, magazines, or journals. Add to these the publications developed by clubs and schools for the deaf (for students and alumni) and it is possible to identify 400 publications aimed at a readership within the deaf community.

Alexander Graham Bell Association for the Deaf
3417 Volta Place, NW
Washington, DC 20007
(202) 337-5220 (V/TDD)

A private, non-profit organization serving as an information resource, advocate, publisher, and conference organizer, the Alexander Graham Bell Association is committed to finding more effective ways of teaching deaf and hard of hearing persons to communicate orally. Sections within the organization focus on the needs of deaf adults (Oral Deaf Adults Section) and parents (International Parent Section).

American Deafness and Rehabilitation Association
814 Thayer Avenue
Silver Spring, MD 20910
(301) 589-0880 (V/TDD)

An interdisciplinary organization for professional and lay persons concerned with services to adult deaf persons, ADARA sponsors workshops for state rehabilitation coordinators.

American Society for Deaf Children
814 Thayer Avenue
Silver Spring, MD 20910
(301) 585-5400 (V/TDD)

Composed of parents and concerned professionals, ASDC provides information, organizes conventions, and offers training to parents and families with children who are hearing impaired.

National Association of the Deaf
814 Thayer Avenue
Silver Spring, MD 20910
(301) 587-1788 (V/TDD)

With 50 state association affiliates and an aggregate membership exceeding 20,000, the NAD is a consumer advocate organization concerned about and involved with every area of interest affecting life opportunities for deaf persons. It serves as a clearinghouse of information on deafness, offers for sale over 200 books on various aspects of deafness, and works cooperatively with other organizations representing both deafness and other disabilities on matters of common concern.

Suggested Readings

Davis, H. and Silverman, R.S. **Hearing and Deafness** (4th ed.) New York: Holt, Rinehart and Winston, 1978.

Freeman, R., Carbin, C.F., and Boese, R. **Can't Your Child Hear? A Guide for Those Who Care About Deaf Children**. Baltimore: University Park Press, 1981.

Gannon, J. **Deaf Heritage**. Silver Spring, MD: National Association of the Deaf, 1981.

Jacobs, L. **A Deaf Adult Speaks Out** (Rev. ed.). Washington, DC: Gallaudet College Press, 1980.

Katz, L., Mathis, S., and Merrill, E.C., Jr. **The Deaf Child in the Public Schools: A Handbook for Parents of Deaf Children** (2nd ed.). Danville, IL: Interstate Printers and Publishers, 1978.

Mindel, E., and Vernon, M. **They Grow in Silence: The Deaf Child and his Family**. Silver Spring, MD: National Association of the Deaf, 1971.

Moores, D. **Educating the Deaf: Psychology, Principles, and Practices** (2nd ed.). Boston: Houghton Mifflin Co., 1982.

O'Rourke, T. **A Basic Course in Manual Communication** (Rev. ed.). Silver Spring, MD: National Association of the Deaf, 1973.

Schlesinger, H. and Meadow, K. **Sound and Sign: Childhood Deafness and Mental Health**. Berkeley: University of California, 1974.

Spradley, T.S. and Spradley, J.P. **Deaf Like Me**. New York: Random House, 1978.

Watson, D. (Ed.). **Readings on Deafness**. New York: New York University Deafness Research and Training Center, 1973.

Directory of Services

The April issue of the **American Annals of the Deaf** is a directory of the various programs and services for deaf persons in the United States. Copies of this reference may be purchased from:

American Annals of the Deaf
814 Thayer Avenue
Silver Spring, MD 20910

Additional Information

If you have specific questions that were not answered by this fact sheet, please contact either the National Information Center on Deafness, Gallaudet College, Washington, DC 20002, or the National Association of the Deaf, 814 Thayer Avenue, Silver Spring, MD 20910.

The National Information Center on Deafness (NICD) is a centralized source of information on all aspects of deafness, including education, vocational training, sign language programs, law, technology, and barrier-free design.

NICHCY
NATIONAL INFORMATION CENTER FOR HANDICAPPED CHILDREN AND YOUTH
P.O. BOX 1492 WASHINGTON, D.C. 20013

Severe and/or Multiple Handicaps

Definition

The term severe handicap indicates an intense degree of a condition such as mental retardation, deafness, blindness, physical disability or emotional disturbance. It may also refer to more than one, or a "multiple" handicap, such as mental retardation and cerebral palsy or blindness and physical disability.

An individual with severe handicaps need not be multihandicapped. Severity describes the degree of involvement in a specific disability.

Incidence

For the 1983–84 school year, the states reported to the U.S. Department of Education that they were providing services to 65,537 children with multiple handicaps. This number represents .17% of the total school enrollment. Severe handicaps are not one of the categories reported.

Characteristics

Children and youth with severe or multihandicaps may exhibit a wide range of characteristics, depending upon the combination of handicaps, the child's age, and the severity of the disabilities. There are, however, some traits that these children may share, including:

- Limited speech or communication;
- Difficulty in basic physical mobility;
- Inability to care for themselves;
- Failure to relate to or attend to others; and
- Tendency toward self-injury or abuse

Medical Implications

Many different medical problems may accompany severe handicaps. A few examples include seizures, hydrocephalus, and scoliosis. These conditions should be taken into consideration when establishing services for the child. A multidisciplinary team consisting of the child's parents, educational specialists, and medical specialists in the areas in which the child demonstrates problems should work together to plan and coordinate the child's services.

Educational Implications

In the past, children with severe and/or multiple handicaps were regularly excluded from the public schools. Since the implementation of P.L. 94–142, the Education for All Handicapped Children Act, public schools are now serving large numbers of severely and/or multiply handicapped students. Some of these children and youths have returned from institutions, others may be entering structured programs for the first time, and still others are graduates of high quality intervention programs.

Educational programs for children with severe and/or multiple handicaps need to incorporate a variety of components to meet the children's tremendous needs. Thus instruction should cover the following areas:

- Academics;
- Communication;
- Sensory stimulation; and
- Self-Sufficiency

Related services are of great importance, and the multidisciplinary approach is crucial. Appropriate persons such as speech and language therapists, physical and occupational therapists, and medical specialists need to work closely with the classroom teacher and parents.

Frequently, classroom arrangements must take into consideration students' needs for medication, special diet, or special equipment. Special aids and adaptive equipment enable the children to increase their range of functioning. In recent years, for example, computers have become effective communication devices. Other aids which may be seen in classrooms include: wheelchairs, typewriters, headsticks (headgear), clamps, modified handles on cups and silverware, and communication boards.

Vocational and leisure skills are a critical consideration for children and youth with severe handicaps. Programming for maximum independence should begin as early as elementary school. To help in post-school adjustment and prepare the student for the greatest degree of independence and self-sufficiency, the program should draw on community services, including group homes, vocational programs, and recreational programs.

Integration with nonhandicapped students is another concern. For many of these students, placement in a special class of a local school allows for interaction during the normal school day.

Editor's Note:

This fact sheet provides information of a general nature. The references and resources provide numerous opportunities to seek more specific information about severe and/or multiple handicaps.

References

Help for Families

Baker, B. L., and others. *Toward Independent Living: Steps to Independence. A Skills Training Series for Children With Special Needs*. 1980. (Research Press, Box 3177, Champaign, IL 61820)
Intended to help parents teach independent living skills to their moderately or severely retarded adolescents, the book focuses on self care, home care, information skills.

Cunningham, C., and Sloper, P. *Helping Your Exceptional Baby: A Practical and Honest Approach to Raising a Mentally Handicapped Child*. 1980. (Pantheon Books, 201 East 50th Street, New York, NY 10022)
The book describes exercises and games to stimulate development of young children with Down Syndrome and other types of retardation.

Doyle, P. B., and others. *Helping the Severely Handicapped Child: A Guide for Parents and Teachers*. 1979. (Thomas Y. Crowell Publishers, 10 East 53rd Street, New York, NY 10022)
This book presents practical suggestions for helping the severely handicapped child at school and at home. There is also a section on special equipment.

Featherstone, H. *A Difference in the Family: Life with a Disabled Child*. 1980. (Basic Books, Inc. 10 East 53rd Street, New York, NY 10022)
The author, educator and parent of a severely handicapped child, writes about parents' and siblings' feelings, marital stress, and both sides of the parent-professional partnership.

Finnie, N. R. *Handling the Young Cerebral Palsied Child at Home*. 1975. (E. P. Dutton, 2 Park Avenue, New York, NY 10016)
The book presents a practical approach (with illustrations) to feeding, dressing, and caring for the young child with cerebral palsy.

Freeman, R. D. and others. *Can't Your Child Hear? A Guide for Those Who Care About Deaf Children* 1981. (University Park Press, Baltimore, MD 21202)
Intended primarily for parents, the guide focuses on total communication as a way of life for deaf children.

Holland, E. *Let's Try to Help: A Guide for Parents of Young Multihandicapped Children* 1976. (Oak Hill School, Connecticut Institute for the Blind, 120 Holcomb Street, Hartford, CT 06112)
Practical teaching methods and activities for parents of blind children with one or more additional handicaps.

Murray, J. B., and Murray, E. *And Say What He Is: The Life of a Special Child*. 1975. (MIT Press, 28 Carleton Street, Cambridge, MA 02142)
Parents of a severely handicapped child describe their encounters with the medical profession, educators, relatives, and friends.

Scott, E. P. and others. *Can't Your Child See?* 1977. (University Park Press, Baltimore, MD 21202)
Written for parents of visually handicapped children, the book includes a section on the needs of multiple handicapped blind children.

Education:

Jegard, S., and others. *A Comprehensive Program for Multihandicapped Children: An Illustrated Approach*. 1980. National Institute on Mental Retardation, Kinsmen NIMR Building, York University, 4700 Keele Street, Downsview, Ontario, M3J 1P3.
The book is designed for parents, teachers and childcare workers involved with multihandicapped and mentally retarded children. The text presents suggestions for developmental activities.

Sailor, W., Wilcox, B. and Brown, L. (Eds.) *Methods of Instruction with Severely Handicapped Students*. 1980. (Paul H. Brookes Publishers, P.O. Box 10624, Baltimore, MD 21204)
This book offers guidelines for the education of students with severe disabilities.

Van Etten, G., Arkell, C., and Etten, C. *The Severely and Profoundly Handicapped. Program, Methods, and Materials*. 1980. (C.V. Mosby Company, 11830 Westline Industrial Drive, St. Louis, MO 63141)
Sections on diagnosis, curriculum, materials and equipment are included in this text on education considerations.

Walsh, S. R., and Holzberg, R., (Eds.) *Understanding and Educating the Deaf/Blind Severely and Profound Handicapped*. 1979. (Charles C. Thomas Publishers, 2600 S. First Street, Springfield, IL 62717)
Fifteen authors contributed papers that focus on evaluation, programming and international education of deaf-blind severely and profoundly handicapped students.

Other:

Blacher, J. *Severely Handicapped Young Children and Their Families Research in Review*. 1984. (Academic Press, Inc., Orlando, Florida 32887)
This book incorporates research conducted with families and educators reflecting the progress of the last decades to improve all aspects of teaching severely handicapped children.

Recources

Cerebral Palsy

United Cerebral Palsy Associations
66 East 34th Street
New York, NY 10016

With its affiliates 1) funds research; 2) advocates for the civil rights of disabled people; 3) provides education programs which emphasize prevention; and 4) provides direct services including medical services, special education, recreation, counseling and adapted housing.

Cornelia de Lange Syndrome

Cornelia De Lange Syndrome Foundation
60 Dyer Avenue
Collinsville, CT 06022

The organization is dedicated to parent/family support, education and research relating to individuals affected with CdLS. Publishes a newsletter Reaching Out and a CdLS Directory.

Deaf-Blind

National Association of Deaf-Blind
2703 Forest Oak Circle
Norman, OK 73071

Founded by parents to further educational, rehabilitation, and employment opportunities for deaf-blind people. Provides information and publishes a newsletter.

Deafness

Alexander Graham Bell Association
for the Deaf
3417 Volta Place, N.W.
Washington, DC 20007

Devoted to providing hearing impaired people with the opportunity to develop and use speech. Provides information and publishes a newsletter.

National Association of the Deaf
814 Thayer Avenue
Silver Spring, MD 20910

NAD recommends and promotes legislation on behalf of deaf people in areas of education, rehabilitation, legal rights for the provision of interpreters, hearing aid regulations, and captioned television.

Down Syndrome

Down Syndrome Congress
1640 West Roosevelt Road
Chicago, IL 60608

With more than 500 affiliates they provide: family support, factual information, bibliographies of materials relating to the disability, local referrals, identification of local resource, and 2 newsletters.

National Down Syndrome Society
146 E. 57th Street
New York, NY 10022

Promotes better understanding of Down Syndrome, the potential of persons with Down Syndrome, and research on the disability. New parent packets of information are available. Toll-free hotline 800-221-4602 NY only 212-764-3070.

Epilepsy

Epilepsy Foundation of America
4351 Garden City Drive
Landover, MD 20785

With over 100 affiliated Chapters and 60 local information and referral services, EFA is involved in advocacy and a wide variety of services and programs for the person with Epilepsy. Publishes a newsletter and other helpful information.

Hydrocephalus

Guardians of Hydrocephalus Research Foundation
2618 Avenue J
Brooklyn, NY 11235

Distributes literature on hydrocephalus. Operates a clinic in New York and runs five chapters in others parts of New York state.

Know Problems of Hydrocephalus
Route 1, Box 210A
River Road
Joliet, IL 60436

Is a parent group for families with children who have hydrocephalus.

Mental Retardation

Association for Retarded Citizens/US
Post Office Box 6109
2501 Avenue J
Arlington, TX 76011

With its state and local chapters, promotes better education, training, job opportunities, and housing for mentally retarded children and adults. Also publishes a newsletter.

Muscular Dystrophy

Muscular Dystrophy Association
810 Seventh Avenue
New York, NY 10019

Provides a full range of services for persons with various types of dystrophy.

Neurofibromatosis

National Neurofibromatosis Foundation
70 West 40th Street, 4th Floor
New York, NY 10018

Promotes public awareness, provides professional workshops, produces publications, and offers referral services.

Prader Willi Syndrome

Prader Willi Syndrome
5515 Malibu Drive
Edina, MN 55436

The association shares knowledge and experience about the syndrome and how to manage it. Publishes a newsletter and other helpful information.

Scoliosis

National Scoliosis Foundation
48 Stone Road
Belmont, MA 02178

Provides educational information including audio-visual materials available for grades 5 through 9.

Scoliosis Association, Inc.
1 Penn Plaza
Suite 3300
New York, NY 10119

Provides education of the general public, sponsors screening programs in schools, and publishes a screening manual for school health personnel.

Spina Bifida

Spina Bifida Association of America
343 South Dearborn Street
Suite 319
Chicago, IL 60604

Emphasizes local parent support groups, of which there are approximately 100 in the U.S. and Canada. Publishes manuals and booklets for parents and teachers.

Tourette Syndrome

Tourette Syndrome Association
Bell Plaza Building
41-02 Bell Boulevard
Bayside, NY 11361

Maintains a clearinghouse of information on Tourette Syndrome. Publishes newsletter and other helpful information

Tuberous Sclerosis

National Tuberous Sclerosis Association, Inc.
Post Office Box 159
Laguna Beach, CA 92652

Brochures, pamphlets for parents, reprints of articles, fact sheets and genetics of Tuberous Sclerosis are available. Publishes a newsletter and maintains a speakers bureau.

Other Helpful Organizations:

ABLEDATA
National Rehabilitation Information Center
4407 Eighth Street, N.E.
The Catholic University America
Washington, DC 20017-2299

Provides information on adaptive equipment and other rehabilitation aids.

Council for Exceptional Children
1920 Association Drive
Reston, VA 22091

Is a membership organization dedicated to advancing the education of exceptional children and youth. Produces publications on special education topics and also conducts computer searches of the literature.

March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605

Supports medical research, sponsors medical services and community services, and act as an information clearinghouse.

National Easter Seal Society
2023 West Ogden Avenue
Chicago, IL 60612

In addition to producing a large number of publications on disabilities, sponsors clinics, research, and workshops.

SKIP (Seek Kids [Need] Involved People)
216 Newport Drive
Severna Park, MD 21146

Serves as a support, resource and educational group to help families to plan a smooth transition from hospital to home for children with various levels of physical instability.

The Association for the Severely Handicapped (TASH)
7010 Roosevelt Way, N.E.
Seattle, WA 98115

Is a membership organization including educators, therapists, researchers, doctors, parents, and others concerned with severely handicapped children and adults. Publishes newsletter, journals, and books.

Trace Research and Development Center for the Severely Communicatively Handicapped
University of Wisconsin-Madison
314 Waisman Center
1500 Highland Avenue
Madison, WI 53706

Has list of publications concerning computers and other communication devices.

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NICHCY
NATIONAL INFORMATION CENTER FOR HANDICAPPED CHILDREN AND YOUTH
P.O. BOX 1492 WASHINGTON, D.C. 20013

Spina Bifida

Definitions

Spina bifida means cleft spine, which is an incomplete closure in the spinal column. The three types of spina bifida (from mild to severe) are:

1. SPINA BIFIDA OCCULTA: There is an opening in one or more of the vertebrae (bones) of the spinal column without damage to spinal cord.
2. MENINGOCELE: The meninges, or protective covering around the spinal cord, have pushed out through the opening in the vertebrae in a sac called the "meningocele". However, the spinal cord remains intact. This form can be repaired with little or no damage to the nerve pathways.
3. MYELOMENINGOCELE: Not only are there openings in vertebrae, but the spinal cord itself does not close. It usually protrudes from the back.

Prevalence

Approximately 40% of all Americans have spina bifida occulta, but very few of them ever know it. The two other forms, collectively referred to as "spina bifida manifesta", occur in approximately one out of every thousand births. Of these, 4% have the meningocele form and 96% have myelomeningocele.

Characteristics

The effect of myelomeningocele, the most serious form of spina bifida, may include muscle weakness or paralysis below the cleft, loss of sensation below the cleft, and loss of bowel and bladder control. In addition, since the spinal cord is the system by which fluid is normally drained from the brain, the fluid may build up and cause hydrocephalus or accumulation of fluid on the brain. 70–90% of the children born with spina bifida have hydrocephalus. Hydrocephalus is controlled by a surgical procedure called "shunting" which relieves the fluid buildup in the brain area. Hydrocephalus may occur without spina bifida, but the two defects often occur together. If a drain (shunt) is not implanted, the pressure buildup can impair the functioning of the brain.

Educational Implications

Although spina bifida is relatively common, until recently most children born with a myelomeningocele died shortly after birth. Now that surgery to close the spine can be performed in the first 48 hours of life, children with spina bifida are much more likely to live. Quite often, however, they must have a series of operations throughout their childhood. School programs should be planned with this consideration in mind.

Many children with myelomeningocele need training to learn to manage their bowel and bladder functions. Some require catheterization, or the insertion of a tube to permit passage of fluids. Catheterization in the schools has been an issue in the courts of some states. Where this issue has been litigated, the courts have held that clean, intermittent catheterization is a related service when it is necessary to help the child benefit from and have access to special education and related services.

Often children with spina bifida who also have a history of hydrocephalus experience learning problems. They may have difficulty with paying attention, expressive and receptive language, reading, and math. Early intervention with children who experience learning problems can make it possible to integrate them with their non-disabled peers when they begin school.

Successful integration of a child with spina bifida into a school attended by non-disabled young people sometimes requires changes in school equipment or curriculum. In the same way as a student placement should be the least restrictive one appropriate for him or her, the day-to-day school pattern also should be as "normal" as possible. In adapting the school setting for the child with spina bifida, architectural factors should be considered. Section 504 of the Rehabilitation Act of 1973 requires that programs receiving Federal funds make their programs accessible. This could mean structural changes (for example, adding elevators or ramps) or schedule or location changes (for example, offering a course on the ground floor). Recent legislation provides up to $40 million in Federal funds throughout the nation for renovation of school buildings to make them accessible.

Children with spina bifida need to learn mobility skills, often with the aid of crutches, braces, or wheelchairs. It is important that all members of the school team and the parents understand the child's physical capabilities and limitations. Physical disabilities like spina bifida can have profound affects on children's emotional and social development. To promote growth, parents and teachers should avoid overprotection and encourage children to take risks within the limits of safety and health. Teachers and classmates should also understand that, although children with spina bifida are physically handicapped, they are more like their classmates than different from them.

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Resources

Information on Spina Bifida

Spina Bifida Association of America
343 South Dearborn Avenue, Suite 317
Chicago, IL 60604
(312) 663-1562
(800) 621-3141 (except Illinois)

March of Dimes Birth Defects Foundation
Post Office Box 2000
1275 Mamaroneck Avenue
White Plains, NY 10605
(914) 428-7100

National Easter Seal Society
2023 West Ogden Avenue
Chicago, IL 60612
(312) 243-8400

National Center for Education in Child and Maternal Health
3520 Prospect Street, N.W.
Washington, DC 20007

Information on Special Education

ERIC Clearinghouse on the Handicapped and Gifted
1920 Association Drive
Reston, VA 22091
(703) 620-3600

Information on Equipment for Children With Disabilities

ABELDATA
National Rehabilitation Information Center
4407 Eighth Street, N.E.
Washington, DC 20017
(202) 635-5090

Accent on Information
Post Office Box 700
Gillum Road and High Drive
Bloomingdale, IL 61701

Information on Design of Accessible Facilities

Adaptive Environment Center
Massachusetts College of Arts
26 Overland Street
Boston, MA 02215
(617) 266-2666

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NEW ADDRESS FOR:

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Rockville, MD 20852

(202) 234-5013
(800) 621-3141

March of Dimes
BIRTH DEFECTS FOUNDATION
1275 MAMARONECK AVE., WHITE PLAINS, NY 10605
Community Services Department

Public Health Education Information Sheet

CONGENITAL HEART DEFECTS

Some 20,000 infants (one out of every 175) are born with heart defects each year in the United States. The defect may be so small that the baby appears healthy for many years after birth, or so severe that its life is in immediate danger. Congenital heart defects account for about one percent of all heart disease in adults.

What Is A Congenital Heart Defect?

A condition is called congenital if it is present at birth. Heart defects begin in the early part of pregnancy when the heart is forming. Congenital heart defects can affect any of the different parts or functions of the heart.

How Does The Heart Work?

The heart is a muscle that pumps blood to the body. It is divided into four hollow parts called chambers. Within the heart are valves (flaps) that let the blood go forward but keep it from going back. Blood goes from the heart to the lungs where it picks up the oxygen it must have. The bright red blood carrying oxygen goes back to the heart. Then it takes the oxygen through the body by way of arteries (tubes). As it uses up its oxygen it becomes darker, and returns to the heart by way of veins (tubes), where the process starts over again.

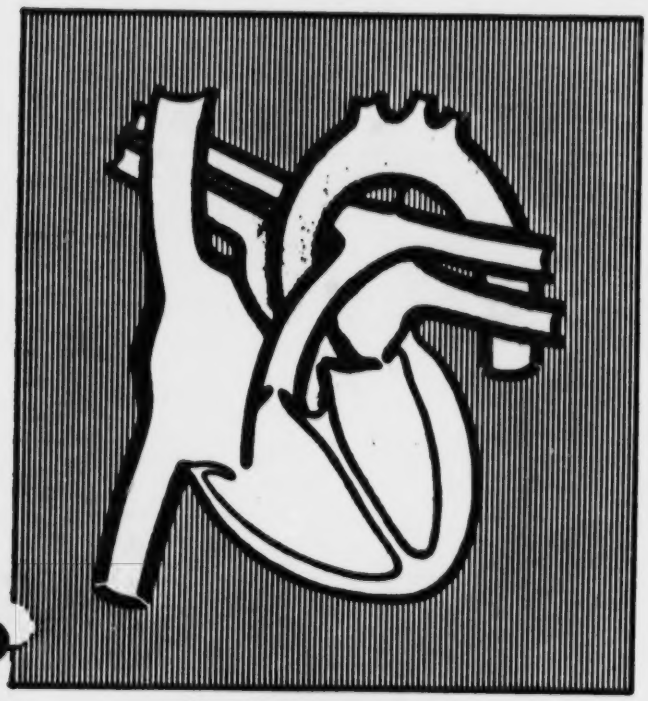

Diagram of a normal heart

How Do Heart Defects Affect A Child?

Some babies are born with a bluish coloring of the skin (cyanosis), especially around the lips, fingers, and toes. This may be normal and soon go away, or it may be the sign of a defect. "Blue babies" have defects that keep their blood from getting enough oxygen. A heart defect also may keep a child from growing and gaining weight normally. He or she may tire easily, feel weak, or have trouble breathing at times. The youngster may squat often because doing that makes it easier to breathe. Symptoms may show up at any age from birth through adulthood.

What Causes Congenital Heart Defects?

In most cases, scientists don't know what makes a baby's heart grow abnormally. Sometimes it is part of a whole pattern of defects that some babies are born with. If a mother has German measles (rubella) during the first three months of pregnancy, her baby's heart may be damaged. (Young women who have never had German measles may be vaccinated against it before they become pregnant.) Heredity may help cause the defect, but how it may isn't known.

How Are Congenital Heart Defects Treated?

Most congenital heart defects can be helped by surgery or medicine. Here are some of the most common defects and their treatment:

- While a baby is in its mother's womb, much of its blood goes through a passageway from one part of the heart to another instead of to the lungs, because the baby gets oxygen from its mother. The passageway should close soon after birth, so the blood can take the normal route from heart to lungs and back. If it doesn't close, blood doesn't flow correctly. A surgeon can close the passageway. In some cases, a new drug makes it close without surgery.
- If the defect is a "hole in the heart" between the two upper or two lower chambers, the blood can't circulate as it should and the heart has to work too hard. A surgeon can close the hole by sewing or patching it. Small holes may heal by themselves.
- Part of the aorta, the large artery that sends blood from the heart to the rest of the body, may be pinched so that the blood can't flow evenly. A surgeon can cut away the pinched part and sew the open ends together.
- Some babies are born with defective heart valves, and blood can't move along smoothly. Surgeons can repair the valves or replace them with man-made ones.
- A combination of heart defects keeps some blood from getting to the lungs for oxygen, and the baby becomes blue and sickly. The baby's brain usually manages to get enough oxygen to prevent mental retardation. Doctors can make temporary repairs until the baby is old enough for final surgery.

Some heart defects can be treated with drugs or mechanical aids such as pacemakers.

Is There A Prenatal Test For Congenital Heart Defects?

Some heart defects can be found through ultrasound, a method of looking at the unborn child using soundwave pictures. In certain heart defects found before birth, drugs can be given to the baby through its mother to help the heart work better. In some cases after the baby is born, the defect may be corrected by surgery. In other cases, where the defective heart can't be treated before birth, doctors can be warned that the defect is present and be ready to give the baby the treatment it needs as soon as it is born.

Can Congenital Heart Defects Be Prevented?

There are no known single, direct methods of prevention. Rubella vaccination and staying away from alcohol and drugs may help.

Genetic counselors can tell parents of affected children roughly what their chances are of having a second child with the same heart defects. Parents who have had an affected child are more likely than others to have a second one with the same defect. But the chances are very small.

What Research On Congenital Heart Defects Is Taking Place?

Scientists funded by the March of Dimes are among many who are trying to learn more about what causes hear defects. Improved treatment and prevention are their goal Investigators are studying the effects of alcohol and drugs on the development of babies before birth. They are especially looking at how different factors affect the development of the heart. And they are investigating new ways to treat heart defects, before and after birth.

For additional copies contact your local March of Dimes chapter.

March of Dimes
BIRTH DEFECTS FOUNDATION

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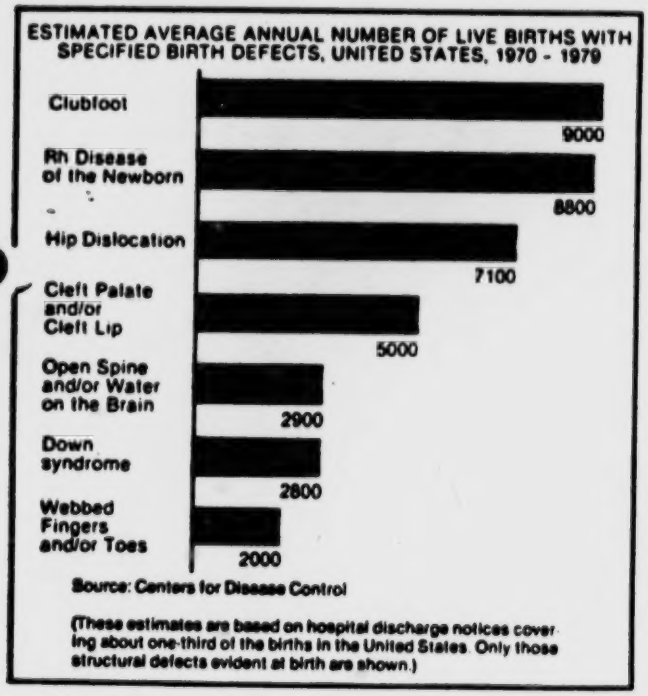
March of Dimes
BIRTH DEFECTS FOUNDATION
1275 MAMARONECK AVE., WHITE PLAINS, NY 10605
Community Services Department

Public Health Education Information Sheet

CLEFT LIP AND PALATE

Some 5,000 children (one out of every 700 births) are born with cleft lip or palate in the United States each year. "Cleft" describes a split where parts of the upper lip or palate (roof of the mouth) fail to grow together. Some have only cleft lip, while more have only cleft palate. About 40 percent have both cleft lip and palate. The defect appears more often among Orientals and certain tribes of American Indians than among white Americans. It occurs less frequently among black Americans.


ESTIMATED AVERAGE ANNUAL NUMBER OF LIVE BIRTHS WITH SPECIFIED BIRTH DEFECTS, UNITED STATES, 1970 - 1979
Clubfoot
9000
Rh Disease of the Newborn
8800
Hip Dislocation
7100
Cleft Palate and/or Cleft Lip
5000
Open Spine and/or Water on the Brain
2900
Down syndrome
2800
Webbed Fingers and/or Toes
2000
Source: Centers for Disease Control
(These estimates are based on hospital discharge notices covering about one-third of the births in the United States. Only those structural defects evident at birth are shown.)

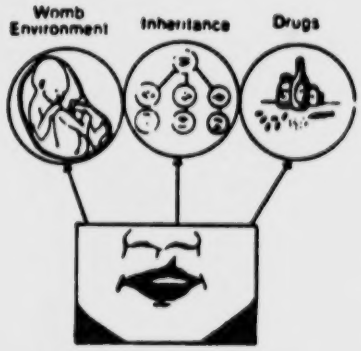
What Causes Cleft Lip and Palate?

There is no one cause for all clefts. Scientists believe that any number of factors such as drugs, disease, heredity, malnutrition, and adverse environment may act on each other to disturb normal growth. Many infants with cleft palate are premature and have other defects.

Heredity appears to play a role in about 25 percent of cases. In the other 75 percent, there is no family history of the defect, even among distant relatives. It is known that if both parents are normal and have a child with a cleft, the chances that subsequent babies will have a cleft increase after each affected child. If either parent was born with a cleft, there is about a four percent risk that their first child will have a cleft, and the chances become greater after each affected birth.

How Do Clefts Affect a Baby's Face?

Cleft lip may involve one or both sides of the upper lip. The split may be only in the upper lip, or may extend up into the nostril. Usually the split goes through the outer skin, muscles, and inside of the lip. Cleft palate may involve only the soft part of the palate toward the back of the throat, or it may extent forward through the hard palate.



Scientists believe that various factors act together to cause cleft palate or cleft lip.

How are Cleft Lip and Palate Treated?

Treatment usually combines surgery, speech therapy, dental corrections, and psychological help. Depending on the type of cleft and infant's general condition, corrective surgery can be started within the first few months. It may be a simple stitching together of the separated edges of the lip; or with a cleft palate, several operations may be necessary. Sometimes tissue grafts are needed. Temporary dental splints or plates are used to keep the upper jaws in proper alignment before and between operations. Braces may be needed later because teeth usually grow in crooked and some may remain impacted in the jaw.

What are the Special Problems Related to Cleft Lip and Palate?

Feeding is the first problem to be overcome. Since a split in the roof of the mouth makes it difficult for a baby to suck, food backs up through its nose and may cause choking. Parents are taught to feed the baby in an upright position, in small amounts, using a nipple with a large hole or syringe. A specially fitted device called and obturator, worn in the mouth, helps in some cases.

Defective speech is one of the most serious results of cleft palate and, to a lesser extent, cleft lip. Psychological problems may result from speech difficulties and the child's unusual appearance before clefts are repaired, and require a professional counselor's help. Clefts have no relation to mental ability or retardation.

Ear infections are common. Difficulty in swallowing affects air pressure around the inner ear through the canal which connects the two. Frequent or severe ear infections may lead to hearing loss.

Can Cleft Lip and Palate be Prevented?

If there is any history of cleft palate or lip in the family, or a history of any other condition of which the cleft is a part, a genetic counselor can assess the chances for passing on the defect.

Non-genetic factors that have been linked to increased risk of clefts include maternal alcohol abuse, diabetes, and treatment with certain anti-cancer drugs or anticonvulsants. Preventive measures therefore include avoidance of alcohol, and medically supervised changes in drug treatment in selected cases. Tighter medical control of diabetes throughout early pregnancy may reduce risk, although this has not been proved. Early and regular prenatal care and good health habits are important for prevention of many birth defects, but cannot guarantee that all babies will be normal.

What Research is Being Done?

Studies have shown that mouth clefts are established before the tenth week of pregnancy. By then, upper jaw and nose tissues have finished growing toward a midline where they fuse to form the palate and upper lip. Because there are so many factors or combinations of factors that may affect this complicated process, research takes many paths.

Scientists are studying the effects on facial development of drugs used to treat epilepsy. Children of epileptic mothers taking anticonvulsant drugs have increased risk of cleft lip and palate. Investigators are also studying genetic differences in body chemistry that may put some individuals at special risk.

Some investigators believe that certain facial characteristics among patients and relatives may help predict the defect. Others continue to explore ways of improving corrective measures and psychological adjustment in children already affected.

For additional copies contact your local March of Dimes chapter.

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1275 Mamaroneck Avenue
White Plains, New York 10605

Genetic Series

Public Health Education Information Sheet

SPINA BIFIDA

Spina bifida is a birth defect of the backbone (spinal column), often called "open spine." Some 1,500 babies (one in 2,000) are born with this condition each year in the United States. It is more frequent in Ireland and Wales, and less common in Israel and among Jewish people in general.

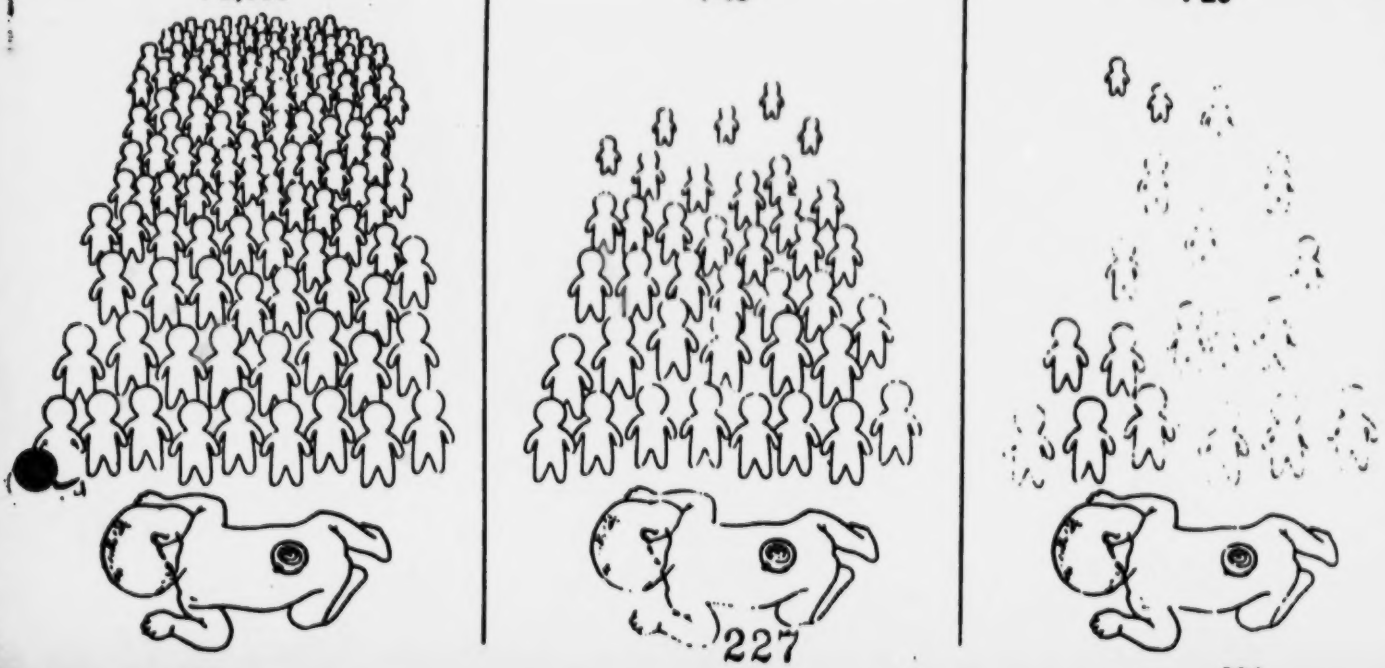
How does spina bifida affect a child?

Every unborn infant's spine is open when it first forms, but normally it closes early in a mother's pregnancy. In spina bifida, the backbone never closes completely. There are three forms of spina bifida:

- The defect may be so slight it never bothers the child and is only discovered accidentally, through an X-ray taken later for some other condition.
- A cyst, or lump, containing part of the spinal cord pokes through the open part of the spine. The lump under the skin can be as small as a nut or as large as a grapefruit, and if it is in the lower back it may cause weakness in the legs. This lump can be removed by surgery, allowing the baby to grow normally.
- In the most severe form of spina bifida, the cyst holds deeper nerve roots of the spinal cord. This lump has little or no skin protecting it. Spinal fluid may leak out, and the area often is covered with sores. Infection is a danger until surgery and healing takes place. Since this severe type is usually at the lower end of the spine, the baby's legs are paralyzed and have no feeling. Poor bladder and bowel control later become a problem.

CHANCES OF HAVING A BABY WITH SPINA BIFIDA

ALL MOTHERS	MOTHERS WITH 1 CHILD AFFECTED	MOTHERS WITH 2 SPINA BIFIDA CHILDREN
1-2,000	1-40	1-20



Hydrocephalus

Hydrocephalus, water on the brain, occurs in 70 to 90 percent of children with severe open spine. This happens when spinal fluid collects in and around the brain, causing the head to become enlarged. If the fluid isn't drained away regularly, mental retardation may result. Hydrocephalus may also occur without spina bifida.

Can spina bifida be treated?

When the spinal defect is so slight that it is hardly noticed, no treatment is needed. If there is a lump but no leg paralysis or loss of feeling, doctors can operate to prevent damage.

When a baby is born with the most severe form of spina bifida, it usually is operated on at once — within 48 hours after birth. Doctors remove the large, runny cyst and cover the wound with muscle and skin. Even so, the leg paralysis and lack of feeling can't be cured.

As soon after the operation as possible, a physical therapist teaches the parents how to exercise their baby's legs and feet to prepare it for walking with leg braces and crutches. Some children may need to use a wheel chair.

If the child develops hydrocephalus, fluid can be drained from its brain through a special tube. The tube runs under the skin, down into the chest, and the fluid passes harmlessly through the child's body.

With treatment, spina bifida patients usually can become active, productive individuals. Most are able to have children, although such a pregnancy is considered "high risk."

What causes spina bifida?

The cause of spina bifida is not presently known. Scientists believe that heredity and some kind of adverse prenatal environment act together to cause this and related central nervous system (brain and spine) defects.

Although spina bifida appears to run in certain families, it doesn't follow any particular law of inheritance. If parents have one spina bifida child, the risk of having a second is about one in 40. If there are two affected children in one family, the risk of having a third is about five percent. There also is a two-fold increase in the chance of having these defect among cousins of the spina bifida baby.

Within each ethnic group where the defect is most common, it occurs about three or four times more often among poor people than among the wealthy.

Can spina bifida be prevented?

At present there is no method to prevent the defect or treat the affected baby before birth. Genetic counseling can help parents of spina bifida children and their relatives by letting them know the odds for having other babies with the defect. Counselors can explain the defect to expectant parents and prepare them for the medical care their child may need. Genetic counselors also will know where the nearest spina bifida clinics or parent organizations are located.

What is the research outlook?

Scientists constantly seek answers to the cause, prevention, and treatment of spina bifida, hydrocephalus, and related defects. Researchers funded by the March of Dimes have been studying the effects of drugs and chemicals of the body on central nervous system development. They are studying how viruses, drugs, growth-promoters and other agents in the earliest stages of a baby's development may influence the way the nervous system grows.

Other investigators are looking for ways to drain fluid from the brain without surgery. They also are studying biochemical changes in parts of the brain affected by hydrocephalus, with the hope of preventing possible brain damage.

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BIRTH DEFECTS FOUNDATION
1275 Mamaroneck Avenue
White Plains, New York 10605

Genetic Series

Public Health Education Information Sheet

DOWN SYNDROME

What Is Down Syndrome?

Down syndrome is a combination of birth defects including mental retardation. Formerly, it was called mongolism because most infants with this birth defect have a somewhat Oriental appearance. "Mental retardation" means that the child does not learn as quickly as other children, due to abnormal brain formation.

What Does A Child With Down Syndrome Look Like?

The child may have oval-shaped eyes, a tongue that seems big for the mouth, a short neck. The head may be flattened in the back and the ears small and sometimes folded a little at the tops. The nose is also flattened and wide. The child or adult with Down syndrome is often short in stature and has unusual looseness of the joints.

How Serious Is The Mental Retardation

The degree of mental retardation varies widely, from mild to moderate to severe. Most fall within the moderate range, but all are retarded to some degree. There is no way to predict the mental development of a child with Down syndrome from the physical appearance.

What Can A Child With Down Syndrome Do?

A child with this birth defect can usually do most things that any young child can do, such as walking, talking, dressing and being toilet-trained. However, they do these things later than other children. As with other children, you never can know exactly at what age these developmental milestones will be achieved.

Can A Child With Down Syndrome Go To School?

Yes. There are special programs beginning in the preschool years to help each child develop skills as fully as possible. These programs continue through the school years and there are special work programs designed for adults with Down syndrome. The extent of achievement is determined by the development of the brain and the social environment in which the child lives.

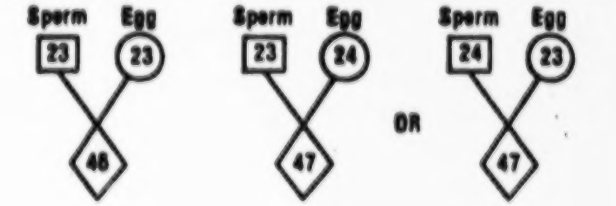
Do Children With Down Syndrome Have Special Health Problems?

Many have heart abnormalities and frequently, surgery can correct these problems. A child with Down syndrome may have many colds, bronchitis and pneumonia. These children, like all others, should receive regular medical care including eye and hearing tests as well as regular immunizations.

Many adults with Down syndrome age faster than their normal age group. Life expectancy among Down syndrome adults is about 50 years of age, but this varies widely.

What Causes Down Syndrome?

A baby is formed when the egg from the mother and the sperm from the father come together. Normally, egg and sperm cells each have 23 chromosomes. Chromosomes are the hereditary information "packets" of every living cell. In the usual case of a child with Down syndrome, either the egg or the sperm cell contributes 24 chromosomes, instead of 23. The result is that the chromosomes present total 47, instead of the normal 46. The extra chromosome causes the mental and physical characteristics of Down syndrome. This cause of Down syndrome is called trisomy 21, because of the presence of three #21 chromosomes. Certain other accidents involving chromosome #21 in egg, sperm or very early embryo also cause Down syndrome, but account for less than 5 percent of cases.



Can A Down Syndrome Baby Be Cured?

There is unfortunately no cure for a child born with this birth defect. Although many claims are made, science has yet to develop the means to prevent the cause of Down syndrome.

Can Down Syndrome Children Marry?

Some young people with Down syndrome have married, but this is unusual. A man with Down syndrome has never fathered a child. A woman with Down syndrome has a 50-50 chance of having a child with the same condition. Many people with Down syndrome require someone to care for them.

Is There Something Wrong With Parents Of A Down Syndrome Child?

Usually not. The phenomenon which causes the extra chromosome can happen in any egg or sperm cell. The extra chromosome can come from either parent. In rare cases it occurs in an embryo formed from a normal egg and sperm, or results from a chromosome rearrangement throughout a healthy parent's cells.

Who Has The Greatest Chance Of Having A Down Syndrome Child?

Parents who have already had a baby with Down syndrome, a mother or father who has a chromosome rearrangement as mentioned above, a mother who is over 35 years old. The chances of an older woman having a baby with Down syndrome are the same whether it is the mother's first pregnancy or not. Down syndrome is the most common genetic birth defect. It affects all races and economic levels of society equally.

Can Down Syndrome Be Diagnosed Before The Child Is Born?

Yes. If there is reason to be concerned about the possibility, a test called amniocentesis can be done in the fourth month of pregnancy. Any family who has a mentally retarded child or a child with other birth defects can discuss the test with a doctor or other health professional who may refer them to a genetic counseling center. The test cannot guarantee the birth of a normal child, but it can indicate whether Down syndrome is present in the fetus.

What Is The March Of Dimes Doing To Prevent And Treat Down Syndrome?

Funding scientific research is the principle means by which March of Dimes is seeking to prevent Down syndrome. Much effort is directed to investigation of the complex structure of chromosomes, and the genes which are contained in all chromosomes, including #21. Other research projects deal with the amelioration of Down syndrome.

For additional copies contact your local March of Dimes chapter

March of Dimes
BIRTH DEFECTS FOUNDATION

This information sheet is made possible through contributions to the March of Dimes.

March of Dimes
Birth Defects Foundation
Community Services Department
1275 Mamaroneck Avenue
White Plains New York 10605
Telephone 914 428 7100

March of Dimes
Preventing Birth Defects

Public Health Education Information Sheet

Rubella

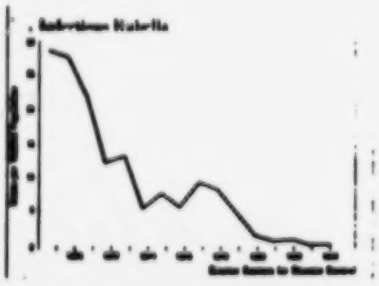
More than 20,000 babies were born with birth defects during an outbreak of rubella (German measles) in 1964 65. Their mothers caught the disease while pregnant, and passed it on to their developing babies. At least 10,000 unborn and newborn babies died of rubella during that same epidemic. Before vaccination against rubella be came possible in 1969, smaller outbreaks hap pened every five to nine years. This cycle of the big outbreaks has been stopped, but rubella still kills or cripples babies before and after birth.

The March of Dimes hopes to wipe out rubella by educating people about the disease and the need to vaccinate against it.

What is Rubella?

Rubella, sometimes also called three day measles, is a mild, infectious (catching) disease caused by a virus. Rubella is not the same as regular measles, which is called rubeola. The two different diseases only sound alike — and both cause skin rashes (redness and itching).

Rubella used to seem so harmless that nobody paid much attention to it until 1941, when doctors began to realize that babies whose mothers caught it early in pregnancy often had birth defects. Although rubella is thought of as a child hood disease, many adults and teenagers get it too.



How Does Rubella Affect a Person?

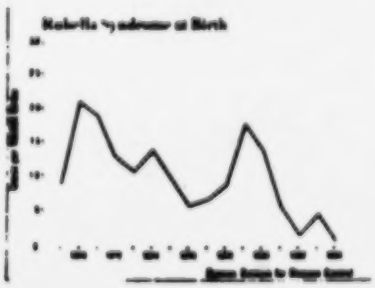
A rash is the first noticable symptom, but rubel la really starts two to three weeks before the rash shows up. This "ripening" time is called the incubation period. A few days before the rash ap pears, the infected person may have painful lumps behind the ears, in the neck, and around the lower back of the head. The tenderness goes away in a day or two, but the swelling lasts longer.

The rash may start on the face and quickly spread down the body, arms and legs. It usually lasts about three days. It may go away before that, and sometimes there may be no rash at all. A little fever usually goes along with the rash. Other symptoms such as headache, loss of appe tite, sore throat, and a general sick feeling are more common in adults and teenagers than in children. After effects of rubella are rare among children, although there have been cases of joint pains, sleeping sickness, and blood clotting prob lems. Adults, especially women, often are left with joint pains.

How Does Rubella Affect an Unborn Baby?

The biggest problem with rubella is the damage it can cause an unborn baby whose mother catches it during pregnancy. The first three months are the most dangerous, but the fetus can still be affected by rubella after that time. The earlier in pregnancy that the mother has rubella, the more serious the birth defects usual ly are. Some "rubella babies" die before or short ly after birth.

More common are the lifetime defects that a baby may be left with. Among these are hearing



loss or deafness; eye defects or blindness; heart defects, and brain and nerve defects, such as mental retardation, slowness in learning to walk and do simple things, and behavior problems.

Some babies may have defects that aren't lasting. They may be born too small, or have feeding problems, diarrhea, pneumonia or anemia (poor blood). Purplish spots may show up on their faces and bodies due to a bleeding tendency. Organs such as the liver and spleen may be irritated and there may be temporary brain and spine problems.

Close follow up of babies affected by rubella is important because some defects don't show up until later in childhood. Even if the baby seems normal at birth, treatment through surgery and training programs often is successful in correcting rubella related defects.

Is There a Test for Rubella?

There is a simple blood test to find out if a person has rubella or has had it at some time in his or her life. People who have had rubella may have rubella antibodies (virus fighters) in their blood. If a blood test shows rubella antibodies are present, then the person has had the disease and can't get it again. The test is important for women of childbearing age even if they think they have had rubella. They may be mistaken, since many infections may look like rubella but really are not.

Can Rubella Be Prevented?

Yes. Vaccination against rubella makes people immune to the disease almost as if they had once caught it. The vaccine causes the body to manufacture rubella antibodies. Rubella vaccination has nothing to do with vaccination against regular measles. *Vaccination against regular measles (rubeola) will not protect against German measles (rubella).*

Since rubella vaccination became possible in 1969, millions of people have received the vaccine. Millions more must be vaccinated each year in order to wipe out the disease for all time.

Who Should Be Vaccinated?

Rubella vaccine is recommended for all children, most teenagers, and many adults (especially women), unless there is a medical reason why they shouldn't have it. If boys and girls are vaccinated, it keeps them from getting rubella and spreading it to others, especially to pregnant women.

Vaccinating girls as soon as they reach childbearing age (after puberty) protects their future babies. Vaccination of teenage or adult groups in colleges, work places or military bases helps prevent outbreaks in those areas.

People working in newborn nurseries should be vaccinated, since infants born with rubella can spread it to the people around them for a while after birth.

When Should a Person Be Vaccinated?

The earliest a child should be vaccinated is 12 months of age. Before that, the baby still has some of its mother's antibodies, which can interfere with the vaccine and keep it from working.

Women of childbearing age should be vaccinated only if they're sure they aren't pregnant and don't expect to be for the next three months. The few women who have received the vaccine within three months before or after getting pregnant have not had infants with rubella related defects, but there is a small risk that such problems could occur. These problems can be avoided by testing women for rubella antibodies before they get pregnant and making sure that those who haven't had the disease are vaccinated well before they decide to conceive.

Persons with fever should not be vaccinated until they are well. But a slight cold, without fever, won't make any difference. Mothers who are breast-feeding may safely be vaccinated against rubella.

Some rubella vaccine formulas contain traces of chemicals that may bother allergic patients, but health professionals can check labels and choose a suitable vaccine.

If a person already has been exposed to rubella, getting the vaccine won't prevent illness, as far as we know. However, there's no reason not to vaccinate children who have been around someone with the disease. Also, there's no harm in vaccinating persons who already have had rubella and didn't know it.

Can Rubella Be Eliminated?

Scientists are constantly working to improve the rubella vaccines, while public health educators try to impress everyone – health professionals, legislators and individuals – with the importance of keeping up with rubella testing and vaccination as each new unprotected generation comes along. Several states require rubella antibody testing of women before marriage, if they are of childbearing age. Pamphlets in marriage license offices remind applicants to be tested or vaccinated.

With these efforts, and with the encouraging results so far, the March of Dimes continues to work for the day when rubella will be eliminated as a cause of birth defects.

March of Dimes
Preventing Birth Defects

This Information Sheet is made possible through contributions to the March of Dimes.

For further information contact your local March of Dimes chapter.

March of Dimes
BIRTH DEFECTS FOUNDATION
1275 Mamaroneck Avenue
White Plains, New York 10605

Public Health Education Information Sheet

CLUBFOOT

Clubfoot has been one of the major orthopedic (bone and joint) problems of children since doctors began to specialize in that field more than two hundred years ago. It is one of the most common of all birth defects, affecting some 9,000 babies (about one in 400) born in the United States each year. Boys are affected twice as often as girls.

What is clubfoot?

Clubfoot is a word used for several kinds of ankle and foot deformities usually present at birth. The defect can be mild or severe, and it can happen to one foot or to both.

There are three major types of clubfoot.

1. When people say "clubfoot" they usually mean the most severe type, known medically as equinovarus. The foot is twisted inward and downward. If both feet are "clubbed," the toes point toward each other instead of straight ahead. The heel cord often is very tight, making it impossible to bring the foot up to a normal position without a specialist's help.

2. A more common type of clubfoot causes the foot to be sharply angled at the heel, with the foot pointing up and outward. This condition is also easier to manage.

3. In the mildest type, the front part of the foot is turned inward. Although present at birth, this form of defect may not be diagnosed until the baby is a month to a few months old. It is rarely very crippling, and the foot can be treated to look and work better. This helps prevent later problems in fitting shoes.

How does clubfoot affect a child?

Clubfoot is not painful and it doesn't bother the baby until he or she begins to stand and walk. Since the ankle is twisted in place, the foot can't move up and down as it normally would in walking. The child must walk as if he were on a peg leg.

If both feet are affected, the child walks on the balls of his feet or, if the feet are badly twisted, on the sides or even the top part of the feet instead of the soles. The part walked on may become infected, hard, and lumpy, and the entire leg often is unable to grow as it should.

Psychological problems often arise when children find themselves walking differently from other children.

What causes clubfoot?

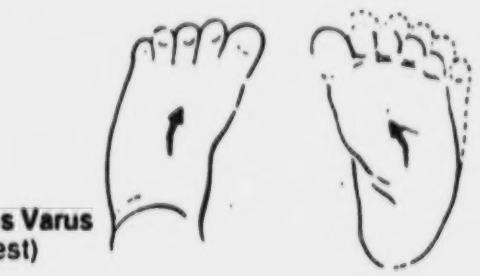
The exact cause of clubfoot still isn't clear. In the past, it often was thought that the baby's feet were twisted or cramped because of the way the baby lay in its mother's womb. This is true only of cases that correct themselves after birth. Many scientists think the defect starts early in pregnancy, before the baby is large enough to stay in one position very long.

Clubfoot probably is caused by a combination of heredity and other factors that may affect prenatal growth, such as infection, drugs, disease, or other factors in the outside environment.

Although most children with clubfoot have no other birth defects, occasionally there are other deformities as well. Children with spina bifida (open spine) sometimes have a form of clubfoot. This is caused by damaged spinal nerves that affect the legs. In other cases, feet which are normal at birth may become twisted as a result of muscle or nerve disease.

Equinovarus
(severe)

Calcaneal Valgus
(most common)



Metatarsus Varus
(mildest)

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Can clubfoot be cured?

Treatment for clubfoot is started soon after birth, often during the first week of life. The aim is to force the twisted foot gradually and gently into place so it can move up and down. In some of the mildest cases, parents are taught how to exercise the baby's foot. More often, plaster casts or surgery followed by exercise are needed.

In the usual method of treatment, the doctor turns the foot forward as far as it can go without pain, and puts a plaster cast on to hold it that way. Every few days, at first, the cast is changed to bring the foot closer to normal. After the foot is straightened, it is tilted further upward to stretch the tightened heel cord. It is kept in this over-corrected position for a few weeks to make sure the foot doesn't slip back when the cast is off. It usually takes about three to six months of treatment, with check-ups for many years after.

Some doctors, in certain cases, use adhesive bandaging over a special kind of splint, instead of casts. After the bandages are off, or in some mild forms of clubfoot, the baby sleeps in shoes attached to a metal bar which holds the feet in a corrected position.

Sometimes the heel cord is too tight to be stretched by a cast or bandaging and the doctor must operate to lengthen it.

Immediate treatment for clubfoot with casts or strapping, without surgery, works in more than half of the cases. In others, some form of surgery is part of the overall treatment.

With expert early treatment, most patients grow up to wear regular shoes, can take part in sports, and lead full, active lives.

Untreated, a clubfoot stays twisted and grows that way. If the defect is treated too late in childhood, surgery may be successful, but the rest of the leg usually can't catch up in growth.

Can clubfoot be prevented?

Although the crippling effects of clubfoot often may be prevented through early treatment, there is no method of preventing the defect at this time. Genetic counseling can help parents understand the odds with each pregnancy for having a child with clubfoot and the outlook for treatment.

What research is being done on clubfoot?

Investigation into the cause and prevention of clubfoot is rarely aimed at that defect alone. It usually is included in scientific studies of birth defects of muscles, nerves and bone in general. The way an unborn baby's muscles and bones grow is affected by so many factors that it will take more years of research to find those that cause clubfoot.

The March of Dimes supports research in immunology, genetics, viral disease, environmental causes of disease, perinatal health care, and other forms of investigation aimed at preventing such muscle, bone and joint diseases as clubfoot.

For additional copies contact your local March of Dimes chapter.

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This information sheet is made possible through contributions to the March of Dimes.

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INTEGRATION RESOURCES

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U.S. Department of Health and Human Services. Mainstreaming Preschoolers. (DHHS Publication No. OHDS 84-31117). Washington, DC: U.S. Government Printing Office.

Winton, P., & Turnbull, A. (1986). Just how special should a preschool be? Ways, January, 7-11.

Below is a list of other excellent examples of training manuals for in-servicing preschool staff involved in integration:

Project Neighborcare Training Manual for Family Day Care (Appropriate for all Early Education Programs), Pierce Hall, Purdue University, West Lafayette, IN 47907.

Mainstreaming Children with Handicaps in Day Care and Preschool, A manual of training activities, Project Mainstream, Madison Area Technical College, 211 North Carol Street, Madison, WI 53703.

Family Day Care Materials, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

Project KIT: Kids in Transition, Educational Resource Book, Northern Trails AEA, Box M, Clear Lake, IA 50428, (515) 357-6125.

Electro Systems, Inc. offers "Young and Special" video tapes on integration issues (See list Figure A5). In Iowa they can be ordered from CNIR. For AEA/LEA's that do not have access to CNIR, contact either the State Consultant, Early Childhood Special Education, Department of Education; or Linda Lewis, Training Coordinator, Des Moines Independent Schools, Smouse School, 2820 Center, Des Moines, IA 50312

CHILDREN'S BOOKS

AGES 3-8

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Wolf, Bernard, Don't Feel Sorry for Paul, Lippencott Company, N.Y., 1974.

A Button in Her Ear/4.95, available from Childcraft, 70 Kilmer Road, Edison, N.J. 07817.

Children's Films

Chesler, B., A Walk in Another Pair of Shoes, California Association for Neurologically Handicapped Children, Los Angeles, CA, 1972/18 min/color.

Describe how it feels to be a child with learning disabilities. 35 mm filmstrip or 35 mm slides with synchronized audio-cassett tape.

David & Goliath, and Noah, Northridge, CA, Joyce Motion Picture Company/18 min/color/16 mm.

Beautiful films in which both voice and signs are used.

RECORDS

"Getting Through: A Guide to Better Understanding of the Hard of Hearing." Chicago, Zenith Radio Corporation, 1971.

"How They Hear: The Sounds of Abnormal Hearing." Northbrook, Il, Gordon Stowe and Associates, 1964.

Both present everyday speech as it sounds to people with various types of and degrees of hearing impairments - an excellent experience. Available at Central WI Center Library.

VIDEO RESOURCE

Young & Special Video Tapes

1. **Not In My Class!** Understanding Mainstreaming
2. **Why Can't They Wait 'til They're Older?** Value of Early Intervention
3. **How Will I Explain It to the Other Children?** Explaining Handicaps to Children
4. **What Do I Tell the Parents?** Working With Parents
5. **Demystifying Special Education** Labels, Individualization, Task Analysis
6. **I Worry About Behavior Management** Principles and Problems
7. **People Who Can Help** Working With Other Disciplines
8. **Can You Really Test Them at That Age?** Identification, Screening & Assessment
9. **How Can You Tell What They Need?** Developing Individualized Educational Plans
10. **Reflexive to Voluntary** Normal Large Motor Development, B-6
11. **But What If She Can't Walk?** Understanding Large Motor Problems
12. **Position Is Everything In Life** Intervention: Large Motor Problems
13. **Reach, Grasp and Release** Normal Fine Motor Development, B-6
14. **When the Eye Is Quicker Than the Hand** Understanding Fine Motor Problems
15. **Like All the Other Kids** Intervention: Fine Motor Problems
16. **Early Thoughts** Normal Cognition, B-6
17. **I Teach Him, But He Doesn't Learn** Understanding Cognitive Problems
18. **Learning to Learn** Intervention: Cognitive Problems
19. **Why Would Being Bright Be A Problem?** Understanding Giftedness
20. **Speaking Louder than Words** Normal Speech & Language, B-6
21. **When Silence Isn't Golden** Understanding Speech & Language Problems
22. **How Can I Get Her To Talk?** Intervention: Speech & Lanugage Problems
23. **You'll Never Believe What She Heard!** Understanding Hearing Impairment
24. **Watch Me Explain** Intervention: Hearing Impairment
25. **Believing Without Seeing** Understanding Visual Impairment
26. **Teaching Children to See** Intervention: Visual Impairment
27. **Let's Not Even Talk About It** Chronic/Terminal Illness & Death
28. **Just A Feeling I Have** Normal Social/Emotional Development, B-6
29. **In A Different World** Understanding Social/Emotional Problems
30. **Love Always Helps** Intervention: Social/Emotional Problems

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Videos can be purchased from:

Electro Systems, Inc.
5400 Walshire Dr.
Columbus, OH 43232
(614) 863-5522

To borrow tapes contact:

Linda Lewis
Smouse School
2820 Center
Des Moines, Iowa 50312
(515) 277-6238

MISCELLANEOUS FORMS

FIGURE A1

(Your center's letterhead)

AUTHORIZATION FOR EXCHANGE OF INFORMATION

_____
(Name of Student)

I hereby grant permission for our agency, the Des Moines Public Schools, and the agencies or schools listed below (or authorized representatives of those agencies and schools) to exchange information related to the above student's management or education, which in their professional judgements may be of value in the continuing care and programming of this child. Such information will not contain sharing of the student's confidential record.

This portion should be filled out before parent/guardian signs.

Name of Individual, Agency, School	Name of Individual, Agency, School
Professional Relationship	Professional Relationship
Street Address Phone	Street Address Phone
City State Zip	City State Zip

Name of Individual, Agency, School	Name of Individual, Agency, School
Professional Relationship	Professional Relationship
Street Address Phone	Street Address Phone
City State Zip	City State Zip

Restrictions or Comments:

Signature Date	Staff Member requesting information Date
Relationship to student	

FIGURE A2

PARENT CONFERENCE/CONTACT RECORD

STUDENT_____ DATES_____

SPECIAL CLASS TEACHER _____ PARENTS_____

REGULAR CLASS TEACHER_____ PARENT'S PHONE_____

SCHOOL_____ GRADE ____

DATE	TYPE OF CONTACT					PURPOSE	COMMENTS
	School	Home	Phone	Letter/ Note	Other		

FIGURE A7

EARLY CHILDHOOD CONTACT FORM

Name \ Date															

CODE: O - Observation
I - Inservice
P - Phone Contact

QUESTIONNAIRE
INTEGRATING HANDICAPPED CHILDREN

Program or Agency _____
Pre/Post

Background Information

1. Indicate your age range:
   a) under 20 b) 20-25 c) 26-35 d) 26-45 e) 46 and over

2. Number of years of experience as a teacher or assistant:
   a) 1-2 b) 3-5 c) 6 or more

3. How much contact have you had with handicapped children in a non-teaching capacity?
   a) none b) some c) often

4. How much contact have you had with handicapped children in a teaching capacity?
   a) none b) some c) often

5. Estimate your comfort level with handicapped children:
   a) comfortable b) unsure c) uncomfortable

6. How much have you interacted with a parent of a handicapped youngster in a teaching capacity?
   a) none b) some c) often

7. How much have you interacted with a parent of a handicapped youngster in a non-teaching capacity?
   a) none b) some c) often

8. Have parents of handicapped young children ever approached you requesting placement of their children in your day care center?
   a) never b) sometimes c) often

1 - Strongly Agree
2 - Agree
3 - Agree Somewhat
4 - Disagree
5 - Strongly Disagree

1.	Many of the things teachers do with regular children in a preschool are appropriate for special-needs children.	1	2	3	4	5
2.	The needs of handicapped children can best be served through special, separate preschools.	1	2	3	4	5
3.	A special-needs child's preschool behavior generally requires more patience from the teacher than does the behavior of the normal child.	1	2	3	4	5
4.	The challenge of being in a regular preschool will promote the academic growth of the special-needs child.	1	2	3	4	5
5.	The extra attention special-needs children require will be to the detriment of the other children.	1	2	3	4	5
6.	Mainstreaming offers mixed group interaction which will foster understanding and acceptance of differences.	1	2	3	4	5
7.	It is difficult to maintain order in a regular preschool that contains a special-needs child.	1	2	3	4	5
8.	The behavior of special-needs children will set a bad example for the other children.	1	2	3	4	5
9.	Isolation in a special preschool has a negative effect on the social and emotional development of a special-needs child.	1	2	3	4	5
10.	The special-needs child will probably develop academic skills more rapidly in a special preschool than in a regular preschool.	1	2	3	4	5
11.	Integration of special-needs children will require significant changes in regular preschool procedures.	1	2	3	4	5
12.	Most special-needs children are well behaved in the preschool.	1	2	3	4	5
13.	The contact regular-class children have with mainstreamed children may be harmful.	1	2	3	4	5
14.	Special-needs children will monopolize the teacher's time.	1	2	3	4	5
15.	Mainstreaming the special-needs child will promote his/her social independence.	1	2	3	4	5
16.	It is likely that a special-needs child will exhibit behavior problems in a regular preschool setting.	1	2	3	4	5
17.	The integration of special-needs children can be beneficial for regular children.	1	2	3	4	5

1 - Strongly Agree
2 - Agree
3 - Agree Somewhat
4 - Disagree
5 - Strongly Disagree

18. Special-needs children need to be told exactly what to do and how to do it. 1 2 3 4 5

19. It is likely that a special-needs child will exhibit behavior problems in a regular preschool setting. 1 2 3 4 5

20. The integration of special-needs children can be beneficial for regular children. 1 2 3 4 5

21. Special-needs children need to be told exactly what to do and how to do it. 1 2 3 4 5

22. Mainstreaming is likely to have a negative effect on the emotional development of the special-needs child. 1 2 3 4 5

23. Increased freedom in the preschool creates too much confusion. 1 2 3 4 5

24. The special-needs child will be socially isolated by regular preschool children. 1 2 3 4 5

25. Parents of a special-needs child present no greater problem for a preschool teacher than those of a normal child. 1 2 3 4 5

26. Integration of special-needs children will necessitate retraining of regular staff. 1 2 3 4 5

27. Special-needs children should be given every opportunity to function in the regular-preschool setting, where possible. 1 2 3 4 5

28. Special-needs children are likely to create confusion in the regular preschool. 1 2 3 4 5

29. The presence of special-needs children will promote acceptance of differences on the part of regular children. 1 2 3 4 5

Adapted from Larrivee and Cook (1979). Mainstreaming: A study of variables of affecting teacher attitude. Journal of Special Education, 13, 315-324.

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FIGURE 6A

IN-SERVICE EVALUATION
INTEGRATING HANDICAPPED CHILDREN INTO EARLY CHILDHOOD SETTINGS

DATE _____

LOCATION _____

TEACHER(S) _____

_____

_____

Overall the course was: __ Excellent __ Good __ Fair __ Poor

1 - Strongly Agree
2 - Agree
3 - Somewhat
4 - Disagree
5 - Strongly Disagree

WORKSHOP CONTENT

1.	I think the information presented in this course will help me in working with handicapped and delayed children in a day care and preschool.	1 2 3 4 5
2.	The methods used (group experiences, worksheets, lecture, brainstorming) were helpful for increasing my knowledge and understanding of the material.	1 2 3 4 5
3.	The format and organization of this workshop was appropriate.	1 2 3 4 5
4.	The handouts were useful as an instructional aid.	1 2 3 4 5
5.	I would recommend another day care or preschool teacher to attend a course like this.	1 2 3 4 5

Adapted from: "Mainstreaming Children with Handicaps in Day Care and Preschool," by Anne Booth et al.

QUESTIONNAIRE
INTEGRATING HANDICAPPED CHILDREN

Program or Agency _____
Pre/Post

Background Information

1. Indicate your age range:
   a) under 20 b) 20-25 c) 26-35 d) 26-45 e) 46 and over

2. Number of years of experience as a teacher or assistant:
   a) 1-2 b) 3-5 c) 6 or more

3. How much contact have you had with handicapped children in a non-teaching capacity?
   a) none b) some c) often

4. How much contact have you had with handicapped children in a teaching capacity?
   a) none b) some c) often

5. Estimate your comfort level with handicapped children:
   a) comfortable b) unsure c) uncomfortable

6. How much have you interacted with a parent of a handicapped youngster in a teaching capacity?
   a) none b) some c) often

7. How much have you interacted with a parent of a handicapped youngster in a non-teaching capacity?
   a) none b) some c) often

8. Have parents of handicapped young children ever approached you requesting placement of their children in your day care center?
   a) never b) sometimes c) often

1 - Strongly Agree
2 - Agree
3 - Agree Somewhat
4 - Disagree
5 - Strongly Disagree

1.	Many of the things teachers do with regular children in a preschool are appropriate for special-needs children.	1	2	3	4	5
2.	The needs of handicapped children can best be served through special, separate preschools.	1	2	3	4	5
3.	A special-needs child's preschool behavior generally requires more patience from the teacher than does the behavior of the normal child.	1	2	3	4	5
4.	The challenge of being in a regular preschool will promote the academic growth of the special-needs child.	1	2	3	4	5
5.	The extra attention special-needs children require will be to the detriment of the other children.	1	2	3	4	5
6.	Mainstreaming offers mixed group interaction which will foster understanding and acceptance of differences.	1	2	3	4	5
7.	It is difficult to maintain order in a regular preschool that contains a special-needs child.	1	2	3	4	5
8.	The behavior of special-needs children will set a bad example for the other children.	1	2	3	4	5
9.	Isolation in a special preschool has a negative effect on the social and emotional development of a special-needs child.	1	2	3	4	5
10.	The special-needs child will probably develop academic skills more rapidly in a special preschool than in a regular preschool.	1	2	3	4	5
11.	Integration of special-needs children will require significant changes in regular preschool procedures.	1	2	3	4	5
12.	Most special-needs children are well behaved in the preschool.	1	2	3	4	5
13.	The contact regular-class children have with mainstreamed children may be harmful.	1	2	3	4	5
14.	Special-needs children will monopolize the teacher's time.	1	2	3	4	5
15.	Mainstreaming the special-needs child will promote his/her social independence.	1	2	3	4	5
16.	It is likely that a special-needs child will exhibit behavior problems in a regular preschool setting.	1	2	3	4	5
17.	The integration of special-needs children can be beneficial for regular children.	1	2	3	4	5

1 - Strongly Agree
2 - Agree
3 - Agree Somewhat
4 - Disagree
5 - Strongly Disagree

18. Special-needs children need to be told exactly what to do and how to do it. 1 2 3 4 5

19. It is likely that a special-needs child will exhibit behavior problems in a regular preschool setting. 1 2 3 4 5

20. The integration of special-needs children can be beneficial for regular children. 1 2 3 4 5

21. Special-needs children need to be told exactly what to do and how to do it. 1 2 3 4 5

22. Mainstreaming is likely to have a negative effect on the emotional development of the special-needs child. 1 2 3 4 5

23. Increased freedom in the preschool creates too much confusion. 1 2 3 4 5

24. The special-needs child will be socially isolated by regular preschool children. 1 2 3 4 5

25. Parents of a special-needs child present no greater problem for a preschool teacher than those of a normal child. 1 2 3 4 5

26. Integration of special-needs children will necessitate retraining of regular staff. 1 2 3 4 5

27. Special-needs children should be given every opportunity to function in the regular-preschool setting, where possible. 1 2 3 4 5

28. Special-needs children are likely to create confusion in the regular preschool. 1 2 3 4 5

29. The presence of special-needs children will promote acceptance of differences on the part of regular children. 1 2 3 4 5

Adapted from Larrivee and Cook (1979). Mainstreaming: A study of variables of affecting teacher attitude. Journal of Special Education, 13, 315-324.

FIGURE P2

IN-SERVICE PLANNING SHEET

EARLY CHILDHOOD CENTER _____

Dates of In-Service:

Topic:	Topic:	Topic:	Topic:	Topic:
Activities:	Activities:	Activities:	Activities:	Activities:

Dates of In-Service:

Topic:	Topic:	Topic:	Topic:	Topic:
Activities:	Activities:	Activities:	Activities:	Activities:

OBSERVATION RATING SCALE FOR TEACHER BEHAVIORS

Teacher _____ Center _____

Observer _____

The underlined letters are the code for the behaviors described. Use information from script-tape to rate observation of teachers' behaviors.

		Observed	Not Observed	NA
I.	Instructional Presentation			
	a. Teacher begins with activity or statementa that focuses children's attention.	____	____	____
	b. Teacher presents the lesson in language understandable to the students.	____	____	____
	c. Teacher provides relevant examples and demonstrations.	____	____	____
	d. Teacher plans activities that students handle with a high rate of success.	____	____	____
	e. Teacher asks questions that students handle with a high rate of success.	____	____	____
	f. Teacher conducts the lesson at a brisk pace.	____	____	____
	g. Teacher makes transitions between activities efficiently.	____	____	____
	h. Teacher makes sure the activity is clear.	____	____	____
	i. Teacher summarizes the main points of the lesson when it is complete.	____	____	____
II.	Management of Instructional Time	____	____	____
	a. Teacher has materials, supplies, and equipment ready at the start of each lesson.	____	____	____
	b. Teacher gets the class started quickly.	____	____	____
	c. Teacher gets the students on-task quickly.	____	____	____
	d. Teacher maintains a high level of student time-on-task.	____	____	____
III.	Management of Student Behavior	____	____	____
	a. Teacher has established routine procedures that govern routine administrative matters.	____	____	____
	b. Teacher has established routine procedures that govern students verbal participation in class activities.	____	____	____
	c. Teacher has established a routine procedure that governs student movement in the classroom.	____	____	____
	d. Teacher frequently monitors the behavior of all students.	____	____	____
IV.	Instructional Monitoring	____	____	____
	a. Teacher circulates during activities to reinforce and encourage children.	____	____	____
	b. Children are supervised well.	____	____	____
V.	Instructional Feedback	____	____	____
	a. Teacher provides feedback on appropriateness of students' responses and behavior.	____	____	____
	b. Teacher provides feedback promptly.	____	____	____
	c. Teacher affirms correct oral responses and moves on.	____	____	____
	d. Teacher provides helpful feedback after incorrect responses.	____	____	____

Adapted from the Carolina Teaching Performance System (Wyne, M.D., White, K.P., Stuck, G.B., & Coop, R.H., 1985).

FIGURE E1

CHILD INFORMATION SHEET

Child's Name _____

Parent(s) Name _____ Phone # _____

Special Education Attendence Center _____

Special Education Teacher _____

Telephone # _____

Child's Strengths _____

_____

_____

_____

Adaptions _____

_____

_____

Goals and Objectives Appropriate for Preschool Setting _____

_____

_____

_____

Comments _____

_____

_____

SOCIAL INTERACTION DATA FORM

Point Time Sample

Classroom/Teacher:_____ Time Started_____

Observer:_____ Activity:_____

Date:_____

Key:T = Teacher Interaction - circle c for child initiates interaction with teacher; or circle t for teacher initiates interaction with child.

INT= Interactive play - circle h if interaction is with another handicapped child or circle n if interaction is with non-handicapped child.

N = Negative interaction - circle o if interaction is with object, circle c if interaction is with another child.

P = Proximity - if playing within 3 feet of another child, occupied with toy or activity, circle o, or u for unoccupied.

ISO= Playing in isolation - Circle o for occupied engagement but away from other children, u for unoccupied and away from other children.

DIRECTIONS: This observation tool can be used to observe from 1-4 children at the same time. Observe one child at the end of the 30 second period for 1-3 seconds, record observation by circling in one of the columns for 2-3 seconds; locate next child to be observed, observe at the end of a 30 second interval for 2-3 seconds, record for 2-3 seconds, etc.

Child's Name	T	INT	N	P	ISO	Total
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	

Child's Name	T	INT	N	P	ISO	Total
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	

Child's Name	T	INT	N	P	ISO	Total
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	

Child's Name	T	INT	N	P	ISO	Total
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	
	c t	h n	o c	o u	o u	

PROBLEM-SOLVING WORKSHEET

Teacher_____

Visiting Teacher_____

Date_____

Problem

Strengths: _____

_____

_____

_____

Possible Solutions:

	Ratings		
	Good	Fair	Poor
1. _____	___	___	___
2. _____	___	___	___
3. _____	___	___	___
4. _____	___	___	___
5. _____	___	___	___
6. _____	___	___	___
7. _____	___	___	___
8. _____	___	___	___

Solution to be tried first:

_____

_____

Classroom adaptions that may need to be made:

Plan of Implementation

Implementation steps:	Who	When
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Expected outcomes:

_____
_____
_____

How will the plan be monitored?

_____
_____
_____

How will progress be evaluated?

_____
_____
_____

Date and time of next appointment:

_____

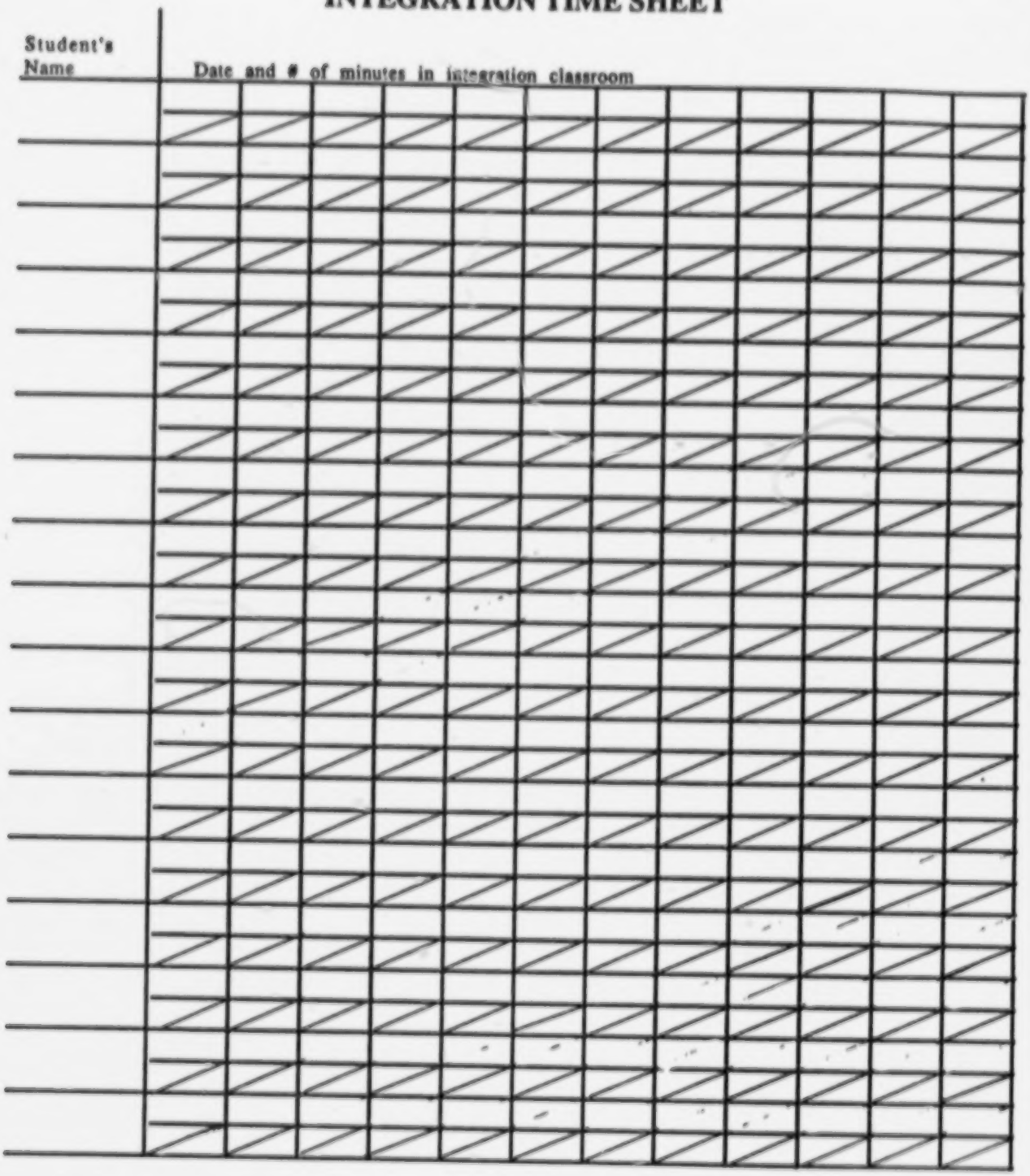
Adapted from: Collaborative Teacher Training Project, University of Kansas

COLLECTING DATA FORM

Behavior observed _____ **Name of Student** _____

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

INTEGRATION TIME SHEET



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Integrating Young Handicapped Children

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DES MOINES, IOWA

Certificate of Training

AWARDED TO

In recognition of their completion of
___ hours of inservice training in
integrating handicapped children
in their setting

PRINCIPAL, SMOUSE OPPORTUNITY SCHOOL

TRAINING COORDINATOR

LET'S PRETEND !

A COLLECTION OF SOCIO-DRAMATIC PLAY

IDEAS FOR THE CLASSROOM

BY: LINDA LEWIS
MICHELLE MILLER
SANDRA RIGGS
CATHY STEWART

A special thanks to Sue Phipps
for typing this booklet

This booklet was made possible through a Phase III Grant through the Des Moines Independent School District. **IT MAY NOT BE COPIED.** Copies can be obtained by contacting:

Linda Lewis
Smouse School
2820 Center
Des Moines, IA 50312

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INTRODUCTION

This booklet was developed for teachers of young children to enable them to teach social skills in a fun way. The suggestions are limited to activities that promote interactions with peers and group participation rather than traditional fine motor and language activities. Teachers are invited to add activities in those areas.

Recent research indicates that by age four or five, children are already beginning to reject those who don't act like themselves. If a child has not learned appropriate social skills by this age, a vicious cycle begins where the socially inappropriate child is not included as often in play, resulting in fewer opportunities to interact and even less improvement in skills.

This ability to interact competently with others is one of the best predictors of adult success. Assisting a child in acquiring social skills should benefit the child throughout his life.

In addition to this booklet, the authors developed sixteen boxes of dramatic play materials. The materials were organized into thematic units that would interest young children and were labeled and made part of a lending library available to other early childhood special education teachers in the Des Moines School District. The dramatic play library provides teachers with a greater variety of materials for classroom use without the expense or difficulty of long-term storage.

The play library is designated to be a teaching tool; **children learn what is in the box and how to use it before the materials are available during the free play situation.**

For the units to be used successfully, the children must be able to relate to their play. Therefore, less familiar areas will require more teaching about the materials in the box and how to use them. **On-going instruction in social skills is an essential component in using this library.**

<u>Adult Role in Teaching Social Skills</u>

The adult's role in the beginning will be more direct and involved in instruction. As children begin to develop social competencies, the adult participates less and becomes more of an observer.

Types of Adult Involvement

1. Parallel Play-Adult is involved beside the child in the same activity. A few comments about the adult's own play may be made. This is non-threatening and indicates the importance of play.

2. Co-Play-Adult joins on-going play episode but the child controls the situation, telling adult what to do. To enter play, make a comment about what's going on. Adult may influence the direction of play or draw other children into play to keep the play going. Useful in helping children who have some play skills but have difficulty persisting in or expanding their play.

3. Play Tutoring-Adult joins the play and directs the action by the role you take. Helpful for children who are having difficulty but very intrusive. Fade quickly when the child learns the skill needed.

4. Observer-Adult remains outside of child's play and takes no role. Adult may make comments or give directions specifically to keep the play going. May address the role the child has taken.

5. Spokesperson for Reality-Adult stays outside the play and makes connections with reality for the children. Children need to be well-grounded in dramatic play for adult to do this so that he can return to the play after the reality break.

Levels of Teacher Participation

High (when child is inappropriate)				Low (When child is more appropriate)
Physical Intervention	**Directive Statements**	**Questions**	**Non-Directive Statements**	**Visually looking on and reinforcing**
-resolve conflicts -introduce props	-assign role -assign tasks -expand play -connect kids	-problem solve -expand play -encourage verbalization	-suggest role play -suggest additional play themes -encourage verbalization	-encourage play -value play -assist only if needed -reinforce appropriate behavior

Six Step Format to Teach a Specific Social Skill

1. Identify the skill needed.
2. Model the skill (2 teachers, 1 teacher with 1 child, 2 children).
3. Role play the skill with each child and the teacher.
4. Evaluate and describe the skill after each role play.
5. Children practice with peers.
6. Provide for generalization of the skill.

Teach in a controlled setting first with adult assistance. Then teach in a more naturalistic setting with little adult assistance.

Ways for Teachers to Promote Peer Interactions

1. Model appropriate interactions for children to see and imitate.

2. Verbally prompt to:
   - solve conflicts
   - expand play
   - suggest role play
   - connect kids
     "Go ask a friend." "Go tell a friend."
     "Did you ask a friend to help?"

3. Make suggestions for children to:
   - share
   - trade
   - invite another to play
   - comment on activities
   - greet others
   - defend themselves

4. Translate or interpret for children who have difficulty having others understand them "Matt said..."

5. Follow through to see that children respond to and answer each other's questions and contacts.

6. Assist children in controlling aggressive behavior by:
   - redirecting
   - reminding
   - providing physical assistance when necessary

Common Places

to Visit

Office

Materials

briefcases	desktop calendar
typewriter	small file box
telephone	dictionary
pens, pencils	men/s & women's clothing
	coffee pot
	include: neckties, hats, shoes, purses
coffee cups	old letters with envelopes

Procedures

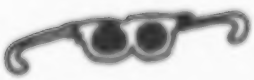
Set a small corner of the room up to depict an office, with a "desk" for the "boss" and secretary. Chairs can be arranged in a line near the secretaries desk for the "clients". Trikes or pretend cars can be used to drive to work in. A visit to an office (perhaps in your building) may be helpful. Try to duplicate some of the items that are seen on the visit in the classroom.

Activities

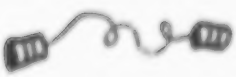
Art

1) Pencil holder-ask each child to bring a can from home. Children can cover with construction paper, then glue on collage materials and use to put crayons, pencils, or scissors in when the "work".

Art



2) Glasses-glasses can be cut from oak tag and decorated with markers. Cellophane can be taped to the back of the glasses or the glass part can be left open.



3) Telephone connection-Telephone skills can be worked on as well as communication between children. Activities could include:

a) telephone cans-attach cans to either side of a long string. Children can take turns talking to each other and pretending they are the boss or secretary.

b) Operating telephones with a control system can often be borrowed from the telephone company. Usually a control panel along with 2 phones is supplied. The control panel controls the ringing and dial tones.

c) Set-up 2 telephones on a table. Practice answering the phone and stating their name.

Art

4) Job Collage-Discuss types of jobs people have i.e. store clerk, teacher, mailman, etc. Children can cut pictures from magazines depicting people working, then glue them on one large sheet of paper and display where children can view it.

Art

5) Briefcases-Children can make their own briefcases by using shoe boxes or office material boxes. Paint the box black or brown and attach a cardboard handle with strong glue. Put pencils and paper in each briefcase. Children can use them in the office corner.

6) Letters-Students can 'write' a letter to someone of their choice or dictate a letter to the teacher, fold the letter, and seal it in an envelope. The letters could be written to others in the room or could be written to someone outside of the classroom and mailed. A walk to the mailbox or post office could be included.

Cooking

7) Lunch break-Lunches can be prepared by the children, either pretend or real brown-bag lunches in a paper bag. During snack they can pretend to eat their lunch in the 'lounge'.

8) Resources-Records: Adventures in Sounds
Books: Kunhardt, D., The Telephone Book.
Sharr, Christine, Telephones.

SCHOOL

Materials	lunch pails backpacks school books pencils teacher clothes bell thermoses chalkboards notebooks attendance envelope principal clothes
Procedures	An area of the room can be arranged to depict the school bus while another area can be arranged to look like either an elementary classroom or a preschool room. Arrangement should be based on what's appropriate for your classroom. For 5 and 6 year olds, the class may want to be depicted as a kindergarten or first grade; for younger children, a preschool room. Roles and activities to be modeled by adults may include; recess, lunch, reading class, group time, color time, etc.
Activities Cooking Game 	1) Sack Lunch-Have children make a sack lunch of peanut butter sandwiches and an apple. The children can have a real lunch time after they ride the "bus" to school The sack lunch may also be eaten with the 'big kids' in the lunchroom if your classroom is in an elementary building. 2) Bus Ride-Make a large bus out of oaktag or bulletin board paper. In the window spaces, glue pictures the children have made of each other. The bus can be hung in the hall or on a low bulletin board. 3) Pass the bell-This game is played like 'pass the button' only a bell is used instead. The bell will give auditory clues as it is passed behind children sitting in a circle with "it" in the middle. The children pass the bell behind them until "it" says STOP. "It" must then guess who has the bell.

Game

4) Four square-A modified four-square can be played by drawing a four square pattern on the carpeting with chalk or by using masking tape. For younger children, students can sit in the squares and roll the ball to each other. If children are capable the ball can be bounced and caught between children until the ball is missed.

5) Teacher for the Day-During the day assign different children to be the teacher. Assistance should be given only when necessary and the adults should back up and watch as much as possible. Start with a child you think would model well. Assignment of 'teachers' could be done when the schedule for the day is reviewed.

6) School Map-Make a list of what rooms are in the school with the children. Draw a map of sorts with students. Take a hike around the school following the map.

7) Safety Walk-Go on a safety walk with the children modeling traffic safety.

8) Red Light-Sing to the tune of "Where is Thumbkin?"

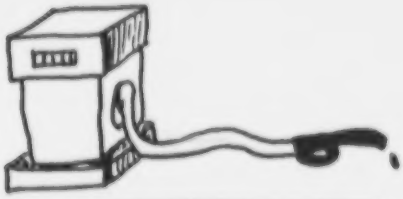
Music

Teacher:	Where is my red light?
	Where is my red light?
Children:	Here I am. (Hold up a stop sign)
	Here I am.
Teacher:	Tell me what you say, sir.
	Tell me what you say, sir.
Children:	I say stop.
	I say stop.

Children can color their own stop signs and hold them up during the song.

9) Resources-Records: Stop, Look, & Listen from Fingerplay Fun, Stop, Look, & Listen from Learning Basic Skills - Health and Safety.
Books: Kessler, Ethel, The Big Red School Bus.
MacDonald, Golden, Red Light, Green Light.

GAS STATION



Materials	Gas Pump (Box with hose & nozzle) Flashlight Scraper/Squeegee "Vehicles" (Trikes, Wagons or Chairs & Steering wheels) Cash Register Play Money, Checkbook and Credit Cards Oil Can and Funnel Sponges, Bucket, Spray Bottle Wrenches & Screwdrivers Gas Attendant Uniforms
Procedure	Divide play space into three areas: the gas lane, car wash and repair shop, and the sales counter, children drive their vehicles to each lane for service, and pay before they leave. Children take turns being gas attendants, car wash workers, mechanics, clerks and customers.
Activities	
Group Activity	1) <u>Wash Vehicles</u>-As a group, children work together to actually wash a car, trikes, wagons or other riding toys. Provide sponges and pails.
Cooking	2) <u>Crunchy Cars</u>-Make a car using 1 1/2 rectangular graham crackers, thick frosting, and cheerios for wheels.
Game	3) <u>Trike Relays</u>-Two teams, each with a tricycle ride down a course leading to a gas station (Box with a hose.) They "fill their tank," ride back and give trike to next team member in line.
Art	4) <u>Sponge Paint</u>-Children work in pairs to sponge paint a large picture of a car or truck (using small pieces of sponge).
Art	5) <u>Construct A Car</u>-Build and paint "a car" as a group using 2 identical 5 sided boxes. Set one box on end inside the other. Paint on wheels and doors, cut out a window, make a steering wheel.

6) Road Building-Use blocks, small cars and plastic people to build roads and gas station.

Sensory

7) Car Wash Blues-Put small cars and sponges in the water table to wash. Add a little detergent and voila! Instant car wash!

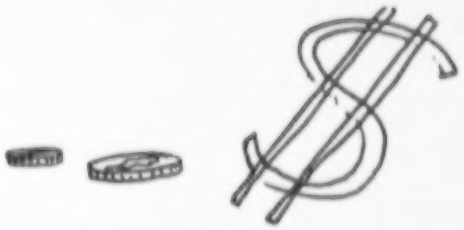
Music

8) Pump the Gas-Sing to tune of Here We Go 'Round the Mulberry Bush

This is the way we pump the gas,
Pump the gas,
Pump the gas.
This is the way we pump the gas,
Right into your car.

9) Gas Pumps-Children can make own gas pumps for the block area by glueing pieces of construction paper to milk cartons. Tape yarn to the side to depict the hose.

BANK



Materials	Checks Deposit slips Stamp & pad Cash Register Traveler's check folders Paper envelopes Money bag Safe Safety deposit boxes Purses Wallets Money (play)
Procedures	One area of the room can be designated as the bank. Teller windows can be made with cardboard windows made from boxes placed on top of tables. A "safe" area can also be created with boxes. Another possibility is a drive-through window. Trikes can be the cars. Adults can model banking activities such as cashing checks, depositing money, obtaining traveler's checks, using safety deposit boxes, etc.
Activities	1) Variable Money-Pretend money can be stones, poker chips, buttons or bottle caps. 2) Safety Deposit Box-Children can check "jewels" in and out of "safety deposit boxes" made from milk cartons attached together in rows and laid down horizontally. 3) Field Trip-The class can visit a bank. 4) Park and Bank-Make parking meters from boxes and wrapping paper rolls. Tape them to the walls and have the children drive cars (trikes), park them by the meters and put dimes in the meters. Walk to the bank.

Music

5) I Gave my Friend a Dollar to the tune of "This is the Way we Wash Our Clothes"

I gave my friend a dollar,
One dollar,
One dollar,
I gave my friend one dollar
One dollar

(Quarter, dime, nickel and penny can be substituted/added.)

6) In Our Bank to the tune of "Mary Had a Little Lamb"

_____(child's name) had a penny,
A penny, a penny.
_____(child's name) had a penny,
And she/he put it in the bank.

Verse 2
We have pennies in our bank,
In our bank, in our bank.
We have pennies in our bank,
Pennies in our bank.

(Both verses can be sung using nickles, dimes, quarters) Children named in the song can take turns depositing various coins in a class bank.

Games

7) Dollar Dollar-Play "Dollar, Dollar" like "Drop the Handkerchief". Have the children chant, "Dollar, dollar, who has the dollar?" Use play money.

8) Wallet Relay-Divide the class into teams. Have a child from each team race to a wallet, take a dollar and bring it back to the next child in the team. Have that child race back to the wallet and place the dollar in it. Continue until all the children have had a turn.

9) Penny Pitch-Have the children pitch pennies into an oatmeal box decorated to look like Lincoln's hat. For less skilled children, use large pennies

made of cardboard or small bean bags with a penny picture.

10) Corn Sort-Label egg carton sections and have the children sort coins into them.

11) Nickel Push-Have the children push nickels from one side of the room to the other using a stick. Continue until each child has had several turns.

Art

12) Potato Prints-Make pretend money by using black paint on potatoes which have been carved to look like money. "Print" the money on green paper. (Remember to reverse the carving on the potato.) Money can be used in the bank play area.

13) $ Tree-Use a piece of driftwood or a tree branch secured in a bucket of sand. Attach money made by the children to the branches.

14) Penny People-Give the children outlines of stick figures. Let them make penny people by gluing pennies on the outline and decorating them as they wish. Children can work in pairs.

15) Coin Rubbings-Let the children make crayon rubbings of coins. Cut holes the size of coins in a shirt cardboard, put coins in the holes and tape paper securely over the coins. Let the children rub the side of a crayon over the paper and images of the coins will appear.

Snack

16) Purchase Snack-Use different coins on different days to purchase snack.

17) Pennies-Make pennies for snack from peanut butter play dough (peanut butter, dry milk and honey to taste) or chocolate cookie dough.

18) Purchase Popcorn-Show a movie and let the children buy popcorn for a quarter a bag and eat while watching the movie.

19) **Banks**-Children can make their own banks by bringing a container (i.e., milk carton, coffee can with lid, oatmeal box, plastic ice cream container). Supply children with paper, tissue paper, glue, scissors, collage materials and decorate! The banks can be decorated as animals or simply as a collage. A slot can be cut in the top for the money.

20) **Books**-Brenner, Barbara, The Five Pennies
Viorst, Judith, Alexander, Who Used to be Rich Last Sunday.

PLANE/AIRPORT

Materials	Suitcases Clothes Tickets Vacation leaflets Maps Cash register/$ Purses	Steering wheel Serving trays Packing-box cockpit Pilot wings Small airplanes Chairs/airplane
Procedures	Airline schedules and travel brochures can be in the home living center to encourage the planning of a trip by airplane. Suitcases should be available to pack and money placed inside purses to be used for purchasing tickets. In the block building area runways can be constructed and small airplanes should be available for takeoffs and landings. A walking board or plank laid across a wooden box can make an airplane. Add a steering wheel or dial panel. Propellers can be cut out of cardboard and thumbtacked or taped to the edge of the plank. A step unit can be pushed up the plane for passengers to get on or off the plane. A wagon can be used to take luggage to and from the plane. Set up two rows of chairs with an aisle between. Section off a galley with a three way screen or other room divider. Provide TV dinner trays with laminated food cutouts and paper cups for the flight attendants to serve to the passengers. Adults can model various activities that occur at tan airport or on an airplane.	
Activities	1) <u>Visit the Airport</u>-If you call ahead to the Public Relations official, the group may be allowed to board an airplane. 2) <u>Walk and Listen</u>-Take a walk and listen for airplanes.	

Music

3) I'm a Little Airplane to the tune of "I'm a Little Teapot" (Bonnie Flemming)

I'm a little airplane; (Raise arms to side a shoulder height)
I can fly. (Turn right arm in front of you for propeller)
Here is my throttle (Reach hand out to instrument panel)
Give me a try. (Push throttle in.)
When I get all revved up (Make engine noises)
Then I fly (Move forward down runway)
Off of the runway (Keep moving forward)
To the sky! (Go up on tiptoe running forward)

4) Fly Low, Fly High to the tune of "Swing Low, Sweet Chariot"

Fly low, fly high today
Fly all over the sky
Fly low, fly high away
Fly low, fly high

5) Ring Around the Rocket Ship

Ring around the rocket ship
Try to grab a star
Stardust, Stardust
Fall where you are.

All join hands in a circle and slide to the right. At the word "grab", drop hands and reach up. At the word "fall", fall to the floor, Repeat verse sliding to the left.

6) Fingerplay: Ten Little Men in Space

One little, two little, three little spacemen
Four little, five little, six little spacemen
Seven little, eight little, nine little spacemen
Ten little men in space.

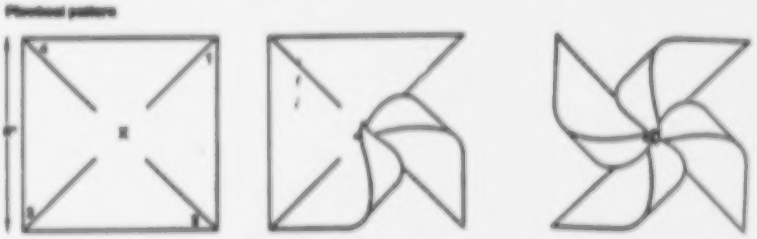
Let each finger be a spaceman. Start with your thumb and wiggle each finger in turn as you name the number.

Game

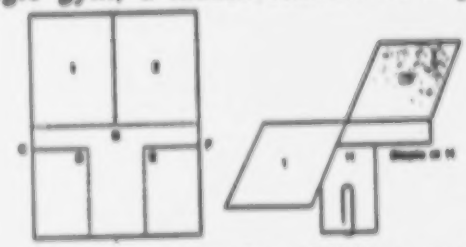
7) Contest-Make paper airplanes and have an airplane flying contest.

Science

8) Pinwheels-Help the children to make paper pinwheels. Let them run, pretending the pinwheels are propellers and they are the airplanes.



9) Helicopters-Help the children to make paper helicopters. Let them drop them from the top of the jungle gym, a ladder climber or a packing box.

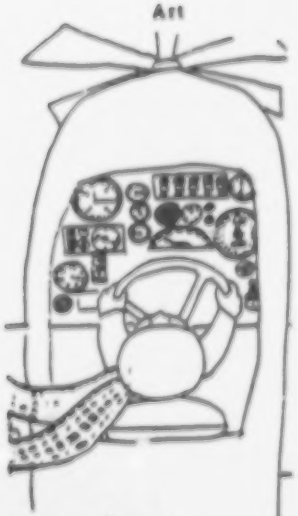


10) Parachutes-Have the children use napkins for parachutes. Let them attache string to the four corners and then to a plastic figure (or a wooden clothes pin decorated to look like a person). The parachutes can be dropped from the top of the jungle gym, stairs or a ladder climber.

11) Windsocks-Take a windsock outside to find out which way the wind is blowing.

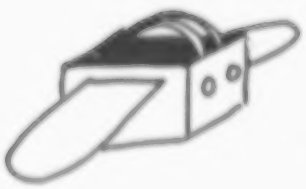
12) Make a Cockpit-To make an instrument panel for an airplane, glue a mirror, old spools and buttons on to a piece of cardboard or a cardboard box. Draw on the speedometer, clock, etc. A steering wheel can be made of cardboard and attached also.

Art



Instrument Panels

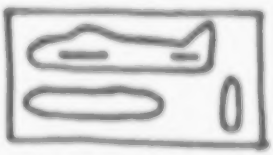
Shops and Stores



13) Box Airplane-Make an airplane from a box with the bottom cut out. Attach wings and a propeller. Straps can be added or the child can hold the airplane in place over his/her body.

14) Clothespin Airplane-Make an airplane using a wooden clothespin and cardboard or pieces of styrofoam for a wing.

15) Styrofoam Airplane-Outline the body and the rudder of an airplane, as well as the wing and tail, on construction paper or styrofoam meat trays. Have the children assemble the airplane, attach a string to it and hang it from the ceiling.



Snack

16) Snack in the Air-Line up chairs in rows with an aisle like the inside of an airplane. Have "stewards or stewardesses" serve snack on trays. (Snacks may be a small sandwich and a pickle wrapped in plastic wrap.)

Books

17) Resources-Books: Bendick, Jeanne, The First Book of Airplanes; Schultz, Charles, Facts and Fun Book About Planes.

FIX-IT SHOP

Materials	Old small appliances (cut-off cords) tool box various tools (screwdrivers, wrenches, etc.) rags work hats or visors work aprons
Procedures	A fix-it area for small appliances can be arranged in a corner of the room. Limit the number of articles to work on to two or three. Parents may be perfect resources for discarded appliances or small mechanical items. Repair stores may also be willing to depart with items that are unrepairable. Some of the items should be take apart so the insides can be seen and worked on. Check to see if some of the parts are too small. This activity may not be appropriate for young children. Two or three children can be the 'fixers while others can be the customers bringing in their items to be repaired.
Activities	1) <u>Practice trials</u>-Children can practice screwing screws by using a large headed screw driver (short handles are easier to handle) with large screw into a thick piece of styrofoam (insulation styrofoam works well). 2) <u>Aprons</u>-Paper aprons can be cut-out of butcher paper, decorated with crayons or markers and worn while in the fix-it shop. Attach reinforcers where the string is attached. 3) <u>Tool prints</u>-Large bolts, screws, nails, and small tools can be used as objects to print with. Dip the ends in paint and dab on a large sheet of paper. Children can make a group picture. 4) <u>Sorting game</u>-A number of items can be sorted by shape and size including screws, bolts, nails, washers, etc. Tools can also be used if there are

Art

Art

enough pairs of tools of likeness to sort. Pairs of children should work on this skill together.

5) Trace around-Place a variety of tools on the table in front of the children as well as a large sheet of butcher paper to fit the bulletin board. Supply the children with crayons or markers. They can lay tool on the paper and trace around it. Tracings can be drawn in a overlapping manner. Have children trade tools with each other.

Game

6) Hide-'n-seek-Tools can be hidden around the room and found by students. Children can take turns hiding the items as well as finding them!

7) Fix-it collage-Children can work in pairs to find items in a catalogue that could be taken to a fix-it shop. Together glue on a large piece of construction paper and display.

Game

8) Find the tool-Pairs of tools will be needed for this game. One tool is put in a tool box while the pair is placed with 1 other or more tools in front of the children. Show child the tool in the box and close the lid. Have the child find the pair in the group of tools on display.

9) Plier pull-out-Put golf tees in a 2"-3" piece of styrofoam. Use pliers to remove them.

Sensory

10) Magnetizing fun-Put a variety of large screws, bolts and nails in a large tub or sand table, along with magnets. Children can use magnets to pick up items. Many small electronic items contain magnets in them.

2.5
2.8
2.2
3.2
2.0
3.6
4.0
100 mm
1.0
1.1
1.25
1.4
1.6
2.8
2.5
3.2
2.2
3.6
2.0
4.0
1.8
ABCDEFGHIJKLMNOPQRSTUVWXYZ
abcdefghijklmnopqrstuvwxyz
1234567890
ABCDEFGHIJKLMNOPQRSTUVWXYZ
abcdefghijklmnopqrstuvwxyz
1234567890
1.0 mm
1.5 mm
2.0 mm
A5
2.0
2.2
2.5
2.8
3.2
3.6
4.0
2.0
2.2
2.5
2.8
3.2
3.6
4.0

Photography Shop

Materials	old cameras film containers mirror * cash register dress-up clothes photo albums comb and brushes *optional
Procedures	Set a section of the classroom up as a photo studio and photography shop. One area could include an area to dress and "primp" and stools to sit on to be photographed. Another area could depict the camera shop with cameras and film containers for sale.
Activities	1) <u>Family photos</u>-ask children a week before the unit to bring pictures of themselves and their families from home. Label them well when they arrive. They can be used for show and tell then displayed within the children's view in the photo studio area.

Art

2) <u>Images of friends</u>-Pair children together and have them draw a picture of their partner. A frame can be cut from poster board and children can decorate the frame. Display the pictures in the hallway or the "studio".

3) <u>Class pictures</u>-Children can invite other classes to their room to have pictures taken. Use an instant camera if possible. Invitations could be made to look like coupons, ie "Free 8 x 10 with class purchase".

4) <u>Camera time</u>-Small cameras can be made from:

a) video tape containers
b) rectangular pieces or styrofoam painted black
c) half pint milk containers with black paper glued around the outside.

Art

Viewfinders, handles, and lenses can be cut from paper or poster board and attached by children. Children can use them in the photo studio to take

pictures of their classmates or "sold" in the camera shop.

5) Smile Collage-Students search of smiles in magazines, cut them out and glue them on a large sheet of paper cut-out as a huge smile together as a group. Young children who would have trouble cutting out the smiles could be supplied with them by the teacher. The students would pick out their favorites and glue them together on the sheet. Display.

Science

6) Sun Photos-On a sunny day, take a hike and have children gather leaves, acorns, etc. They can tape them on a dark blue piece of construction paper to a side walk in a sunny spot. Arrange 'finds' on the paper. After a couple of hours check to see if an imprint can be seen. A language lesson about what the sun does can be incorporated.

BEAUTY PARLOR

Materials

Hair dryer
Plastic brushes
Combs
Cotton Balls
Scarves
Make-up
Plastic aprons
Head bands
Towels
Nail polish
Wigs
Ribbons
Rollers
Barrettes
Empty spray cans
Hand mirrors
Rubber bands

Procedures

An area of the room can be arranged to depict a beauty parlor with chairs in front of mirrors, small tables displaying hair-styling equipment, a table for manicures and an area for "facials." Adults can demonstrate various activities such as putting hair in rollers, blow-drying hair, styling, giving manicures and applying make-up. Put up barber poles and a sign for fun.

Activities

1) Wig Trimming-Have the children trim hair on wigs with scissors.

2) Hair Care for Dolls-Have the children comb and brush dolls' hair.

3) Hairdressers-Have the children role play being hairdressers. Let them put towels around "customer's" necks and pretend to wash, cut, set and style hair.

4) Classroom Visitor-Ask a hairdresser to come to your class to talk with the children and show the tools he/she uses.

Science

5) Magnifying Hair-Cut a small amount of your hair. Look at hair under a magnifying glass.

6) **Evaporation**-Let the children dry wet spots on a blackboard with a hair dryer. Discuss evaporation.

7) **Manicures**-Have the children role play giving a manicure.

8) **Facials**-Have the children give "facials."

9) **Face Painting**-Have a visitor do fact painting. Role play.

Music

10) **The Barber**-Sing to the tune of "Here We Go "Round the Mulberry Bush"

This is the way the barber works (Snip with scissors)
Barber works, barber works. (Snip with scissors)
This is the way the barber works (Snip with scissors)
So early in the morning. (Snip with scissors)

Music

11) **Snipping Song**-Sing to the tune of "Baa, Baa Black Sheep"

Snip, snip, snip, snip
Take the scissors up.
The barber used the scissors
To give me a haircut.

Music

12) **Brush my Hair**-Sing to the tune of "Row, Row, Row your Boat".

Brush, brush, brush my hair
Brush my hair so neat
Brush, brush, brush my hair
Brush my hair so neat.

Game

13) **Ping Pong Exercise**-Let the children chase ping pong balls around with a hair dryer ... or... use a hair dryer to blow ping pong balls for children to "catch."

Game

14) **Shampoo Target Practice**-Fill several empty shampoo bottles with water. (Be sure the bottles have squeeze tops.) Make a target on pavement or on an outside wall and let the children squirt water at the target.